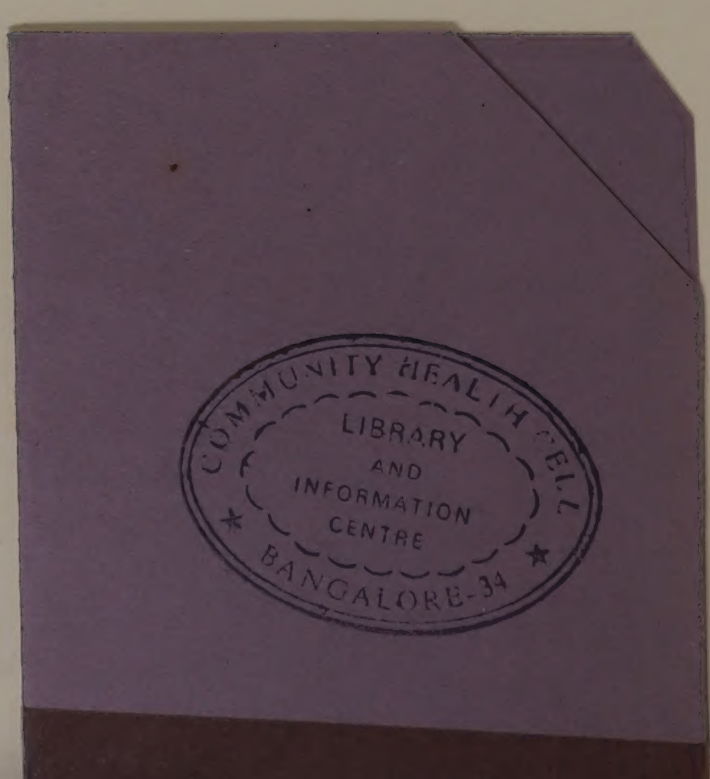
GOVERNMENT OF THE REPUBLIC OF ZAMBIA
MINISTRY OF HEALTH

HEALTH BY THE PEOPLE
IMPLEMENTING PRIMARY HEALTH CARE IN ZAMBIA

THE PLANNING UNIT, JANUARY 1981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FOREWORD

In January, 1980 my Ministry published the first edition of this document which put forword proposals for the establishment of Primary Health Care as a means of goals of the Party and its Government.

During 1980 the proposals were debated throughout the nation at seminars conducted in the Districts, Provinces and at Central level.

Arising from the national debate a number of amendments and additions to the proposals were put forward. These have been incorporated into this document, the final version of Health by the People, which will serve to guide the implementation of Primary Health Care in Zambia during this and subsequent decades.

R. KUNDA, M.P.,
MINISTER

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1. INTRODUCTION TO PRIMARY HEALTH CARE

1. DEFINITION

Primary health care is essential health care made universally accessible to individuals and families in the community by means acceptable to them, through their full participation and at a cost that the community and country can afford. It forms an integral part both of the country's health system of which it is the nucleus and of the overall social and economic development of the community.

(Alma Ata 1978. WHO/UNICEF Joint Report)

2. BACKGROUND

The concept of primary health care, as defined above has evolved gradually over a number of years as it has become increasingly obvious that conventional systems of medical care have failed to make an adequate impact on the health of the vast majority of the people of the world. As always the people of the less developed countries have suffered and continue to suffer most severely.

The main problem has stemmed from the adoption of a system of medical care originally developed in the industrial countries. This system places emphasis on curative medicine, i.e. the treatment of illness when it occurs, rather than on prevention of disease. Increasingly such a system relies on complex high technology methods which require highly trained personnel to carry out. Increasingly it is also highly expensive and has reached such a level that no country, including developed industrial nations, can afford to offer all its citizens a standard of care to match the potential which exists.

Zambia, like most other countries, has tried hard to develop a system of health care for her people. Indeed the record of achievement is one of which Zambia can rightly be proud. Expenditure on health each year now amounts to approximately K11 for every citizen, much more than the vast majority of less developed countries. However this money could have been used to better effect.

2.1 Deficiencies

The available resources have not been distributed equitably. The three Central and three Special hospitals have consumed a disproportionate amount of

the health budget. In addition these hospitals are based in urban areas and are not accessible to the majority of the people.

It has been calculated that Lusaka and the urban Copperbelt, with only 30 per cent of the population, consume 60 per cent of national health expenditure. Thus 70 per cent of the people living mainly in the rural areas are left with only 40 per cent.

On a per capita basis it has been calculated that each member of the urban population receives approximately K9 of government health expenditure each year compared with K5.5 for the rural population (based on 1978 figures)

The existing system of health care places too much emphasis on treatment rather than on prevention of disease and promotion of good health.

TABLE 1 below shows the major causes of death and illness in Zambia

SOME CAUSES OF MORTALITY AND MORBIDITY
AT HEALTH CENTRES IN ZAMBIA
(by diagnosis) - 1979

DIAGNOSIS	MORTALITY (% OF TOTAL DEATHS)	IN-PATIENT (% OF TOTAL ADMISSIONS)
MEASLES	19.9	6.9
MALNUTRITION + ANAEMIAS	15.5	4.4
PNEUMONIA	14.1	5.4
MALARIA	11.3	19.5
DIARRHOEA	9.9	7.7
UPPER RESPIRATORY TRACT INF.	2.4	6.3
OTHER ABDOMINAL CASES	2.1	4.8

(cont)

DIAGNOSIS	MORTALITY (% OF TOTAL DEATHS)	IN-PATIENT (% OF TOTAL ADMISSIONS)
INJURIES	1.1	5.4
OTHER PULMONARY CASES	0.8	1.8
JAUNDICE	0.8	0.3
TOTAL	77.9	62.5

All of these diseases are preventable through measures available in Zambia. Thus an expensive urban based medical system which relies on treatment rather than on prevention is clearly NOT an effective way to tackle the nation's health problems.

3. THE PRIMARY HEALTH CARE APPROACH

Primary health care is a practical approach to making essential health care universally accessible to individuals and families in the community in an acceptable and affordable way and with their full participation.

Implicit in this community based approach is the concept that improvement in health is an integral part of overall community development. The healthier people are the greater is their ability to contribute to the social and economic development of their communities and the nation as a whole.

Primary health care aims to tackle the main health problems in the community with particular emphasis on under served, high risk and vulnerable groups. Thus in Zambia special attention will be paid to the rural and periurban areas where the health needs of the people are greatest.

TABLE 1 shows that the main health problems in Zambia are preventable. Primary health care places major emphasis on disease prevention and promotion of good health practices while also providing treatment for common illnesses and injuries.

3.1 Community participation

In order to achieve its declared aim for making health care accessible to all the people the nation must make effective use of all its resources. The most important resource is the population itself.

The people must become actively involved in all aspects of primary health care from planning and development through implementation to the day to day management of primary health care activities in their communities. Only in this way can services spread quickly to those in greatest need and only in this way will the services be acceptable to the people and be supported by them.

Active community participation is fundamental to the whole primary health care approach. Primary health care begins at community level starting with the establishment of a dialogue between community representatives and the local health centre workers. In this way the community participates in the identification of their health needs, the setting of priorities and formulation of local plans. They also learn from the explanations and advice of the health workers.

Of course the people cannot participate effectively without explanation, education and motivation. This must be the responsibility of the health centre staff and, more importantly, the Community Health Worker, a new cadre, based in every community. The task of this worker is to educate and motivate the local people to join in taking action on their own behalf against local health problems. He must also have the skills to treat simple common illnesses and injuries.

In order to carry out his tasks effectively the Community Health Worker must have the full confidence of the people. Therefore he must be selected by the people themselves from within their own communities and then trained to provide primary health care services.

3.2 Support from other sectors

No sector involved in community development can work effectively in isolation. Interdependence is such that activities in one sector have an impact on the goals of another. For example, food production, safe water supply, sanitation, housing and education all contribute to health and share the same goal of improving the quality of life. For maximum benefit it is essential that all sectors fully appreciate their roles in overall community development and their relationships with one another. Thus there is an

essential need for effective co-ordination at all levels between health and all other related sectors.

Health system support

Primary health care must be the nucleus of the national health system. However it cannot function without support. Community Health workers cannot function without backup and guidance from more skilled health workers. These workers are the Medical Assistant, Health Assistant and Enrolled Nurse based in the health centres.

In order to introduce primary health care throughout Zambia many more health centres will be needed and many more staff trained to staff them adequately.

Detailed proposals for establishing an effective backup system are included in subsequent chapters.

IMPLEMENTING PRIMARY HEALTH CARE IN ZAMBIA

For primary health care to succeed in Zambia there must be a clear understanding and acceptance of the concept that health is one component part of overall community development. The two fundamental requirements for primary health care follow from this concept. These are as follows:-

- active community participation
- co-operation and co-ordination between all sectors engaged in community development

Fortunately the need for these has long been recognised in Zambia, as the following excepts from the Party Constitution illustrate.

> "The rural areas still face hunger, poverty, ignorance and disease. The answers to these lie not only in Government policy but in people organising themselves for action ...
>
> Village Productivity Committees, Ward Councils and Ward Development Committees are being established to help organise community action to defeat these enemies which have plagued society from time immemorial. The provision of an adequate machinery at village level must increase the capacity of man in the village to fight to improve his economic and social conditions ...
>
> The basic requirements of a decent life must be:-
>
> First: More food and an improved diet
> Second: Better health and improved sanitary conditions
> Third: Improved shelter that is houding
> Fourth: Better clothing
> Fifth: Better education

Government action is geared to achieve these ends but it cannot achieve them alone unless the people who are being served are prepared to work hard in co-operation with the Party and Government to achieve higher productivity in every sector of economic and social life."

The recent changes in Party machinery with the replacement of Village Productivity Committees by Section Committees and the forthcoming decentralisation of local government both will contribute considerably to making community participation and local decision making effective.

However there is another vital element necessary for effective community participation in primary health care. The people must understand and accept primary health care as a mean of improving their health.

In order to promote such an understanding the Ministry of Health has conducted seminars throughout Zambia - at national level, at Provincial level and at District level. At the time of completing this document January, 1981, in some Provinces seminars have already reached the level of Chiefs and Ward Councillors and even Village Headmen and Section leaders.

This process of informing, of discussion and consultation must continue until all the people know and understand about primary health care and can decide whether to accept it.

At the same time the Ministry of Health has been continuing the task of strengthening its services in keeping with current policies. With emphasis on services in rural areas detailed preparations have been made for the training of more health workers and improvements in transport and communications. More new health centres are being constructed and improvements, including the construction of staff housing are being carried out at existing health centres.

But this is just the beginning. There must be no illusions about the tasks ahead. They will require time and a lot of effort. However only through such efforts can the ultimate goal be achieved - health for all in Zambia.

Chapter 1.2 ANALYSIS OF EXISTING SITUATION

1. DEMOGRAPHY
2. HEALTH STATUS
3. HEALTH RESOURCES AND SERVICES
4. EXCERPT FROM TNDP

2. ANALYSIS OF EXISTING SITUATION

Zambia with an area of 752,600 sq. km. and a population of 5,649,000 (1979 estimate), has a general population density of about 7.6 per sq. km. The regional variations range from 4 to 40 people per sq. km.

1. DEMOGRAPHY

TABLE 2 shows some recent major demographic indices from various sources while trends over the past 30 years are illustrated in TABLE 3. The trend in population composition has been fairly constant (TABLE 4). The age groups 0-14 years constitute 46.8% of the total population. It is also significant that children under 15 years and women of child bearing age (15-49) constitute close to 75% of the population in any given year.

The population distribution is changing fast as a result of rural urban migration. Zambia has one of the highest birth rates and natural population growth rates in the world. This is so firstly because although the fertility remains high (in fact increasing) the death rate is decreasing. Secondly, Zambia is one of the countries where family planning is little practiced.

TABLE 2

SOME RECENT DEMOGRAPHIC INDICES

Crude Birth Rate/	50/1000
Crude Death Rate/	19/1000
Natural Annual increase (%)	3.1 - 3.2
Life Expectancy ... Males	46.7
Females	50.0
Peri-natal mortality	50/1000 live births
Infant mortality Rate	140/1000 live births
Child mortality Rate (1-4yrs)	197/1000 live births
Maternal mortality	14-10/10,000 live births
Under 15 years (%)	46.8
Women 14 - 49 years (%)	24.2
Average house size	6

SOURCE: Various Sources 1975 - 79

TABLE 3

EVOLUTION OF VITAL POPULATION CHARACTERISTICS, SELECTED YEARS

YEAR	CBR	CDR	IMR	LIFE EXPECTANCY
1950	56.8	32.0	259	n.a.
1963	51.0	19.6	n.a.	40 (Both)
1969	47.7	19.7	147	41.8 (Male) 45.0 (Female) 43.4 (Both)
1974	48.6	20.3	141	44.3 (M) 47.5 (F) 45.9 (B)
1979	52.0	21.0	140	46.7 (M) 50.0 (F) 48.3 (B)

n.a. = not available
CBR = Crude Birth Rate
CDR = Crude Death Rate
IMR = Infant Mortality Rate

TABLE 4

TRENDS IN POPULATION COMPOSITION BY AGE AND SEX (AS A % OF TOTAL POPULATION)
SELECTED YEARS

AGE	YEAR TOT. Pop.	1950 2,473,000		1960 3,219,000		1970 4,295,000		1975 5,022,000		COMBINED Mean
		M	F	M	F	M	F	M	F	
0-4		9.8	9.7	9.7	9.7	9.3	9.6	9.9	9.9	19.4
5-9		7.3	7.4	7.5	7.5	9.9	8.0	7.2	7.5	15.1
10-14		6.1	6.1	6.2	6.2	5.9	5.5	6.6	6.6	12.3
15-19		5.1	5.1	5.2	5.2	4.3	4.8	4.9	4.6	9.8
20-24		4.3	4.3	4.4	4.5	3.3	4.6	3.6	3.9	8.2
25-29		3.5	3.5	3.6	3.6	3.1	4.0	2.7	3.8	6.8
30-34		2.9	3.0	3.0	3.0	2.9	3.5	2.6	3.3	6.1
35-39		2.4	2.3	2.4	2.5	2.9	3.0	2.5	3.3	5.3
40-44		2.0	2.1	2.0	2.0	2.2	2.1	2.3	2.9	4.4
45-49		1.3	1.7	1.6	1.7	2.1	1.9	1.7	2.4	3.6
50-54		1.1	1.3	1.2	1.3	1.5	1.4	1.7	1.7	2.7
55-59		0.9	1.1	1.0	1.1	1.6	1.0	1.1	1.1	2.2
60-64		0.9	0.9	0.7	0.8	0.7	0.6	1.2	0.8	1.7
65-69		0.6	0.7	0.5	0.6	0.7	0.7	0.5	0.5	1.2
70+		0.8	1.1	0.7	0.9	0.5	0.4	0.7	0.5	1.3

SOURCE: W.C. Mwambazi. Percentages computed from "Population by Sex and Age for Regions and Countries 1950 - 2000 as assessed in 1973: Medium Variant", U.N. Secretariat, Population Division (Feb. 1976)

The population projection for the TNDP shows that the population will have increased from 5,472,000 in 1978 to 6,655,000 in 1984 and will have the distribution as shown in TABLE 5.

TABLE 5

RURAL - URBAN POPULATION DISTRIBUTION BY PROVINCE
(THOUSANDS)

	1978		1984	
	RURAL	URBAN	RURAL	URBAN
Central + Lusaka	433(38)	718(62)	471(30)	1057(70)
Copperbelt	86(7)	1217(23)	95(6)	1645(94)
Eastern	616(96)	20(4)	708(96)	27(4)
Luapula	340(95)	16(5)	351(95)	20(5)
Northern	583(93)	45(7)	617(89)	73(11)
North-Western	276(97)	9(3)	314(96)	12(4)
Southern	478(80)	113(10)	596(76)	155(24)
Western	507(97)	15(3)	588(96)	20(4)
All Zambia	3319(60)	2153(40)	3650(54)	3005(46)

SOURCE: Adapted from TNDP
figures in brackets represent percentages

2. HEALTH STATUS

Analysis of available data and information (see TABLES 1 and 2) suggests that the overwhelming priority problems are related to maternal and child health as well as socio-environmental factors. Mothers and children constitute the majority of the population. They are particularly vulnerable and subject to disease. Perinatal mortality has been reported to account for 15-40% of hospital mortality of patients under the age of 15 (Children) in 1978. Moreover deliveries alone constitute the most frequent cause of admission to hospitals.

The fact that more than 90% of hospital and health centre deliveries are hormal calls for a serious approach to planning secondary care-based maternity services. In addition the numbers of mothers delivering in health institutions is increasing at such a rate that the facilities cannot cope (especially the large hospitals). Countries where the percentage of hospital deliveries approaches 100% of total deliveries are now encouraging "home deliveries" i.e. de-

institutionalising child birth. Serious consideration must be given to the introduction of similar practices in Zambia.

TABLE 6 and 7 show the pattern of pregnancy outcome for the period 1975-78.

TABLE 6

RECORDED LIVE BIRTHS, STILL BIRTHS, ABORTIONS, IN RURAL HEALTH CENTRES

EVENT	1975	1976	1977	1978	1979
LIVE BIRTHS	24,271	26,002	26,222	26,032	26,540
STILL BIRTHS	591	559	566	2,380	535
ABORTIONS	670	706	756	892	925
TOTAL PREGNANCY OUTCOME	25.532	27,267	27,544	29,304	28,000

TABLE 7

RECORDED LIVE BIRTHS, STILL BIRTHS, ABORTIONS IN HOSPITALS

EVENT	1975	1976	1977	1978	1979
LIVE BIRTHS	82,024	82,532	88,453	80,361	80,270
STILL BIRTHS	2,545	2,588	2,821	2,640	2,610
ABORTIONS	10,376	10,793	11,328	10,827	12,220
TOTAL PREGNANCY OUTCOME	94,945	95,913	102,602	93,828	95,100

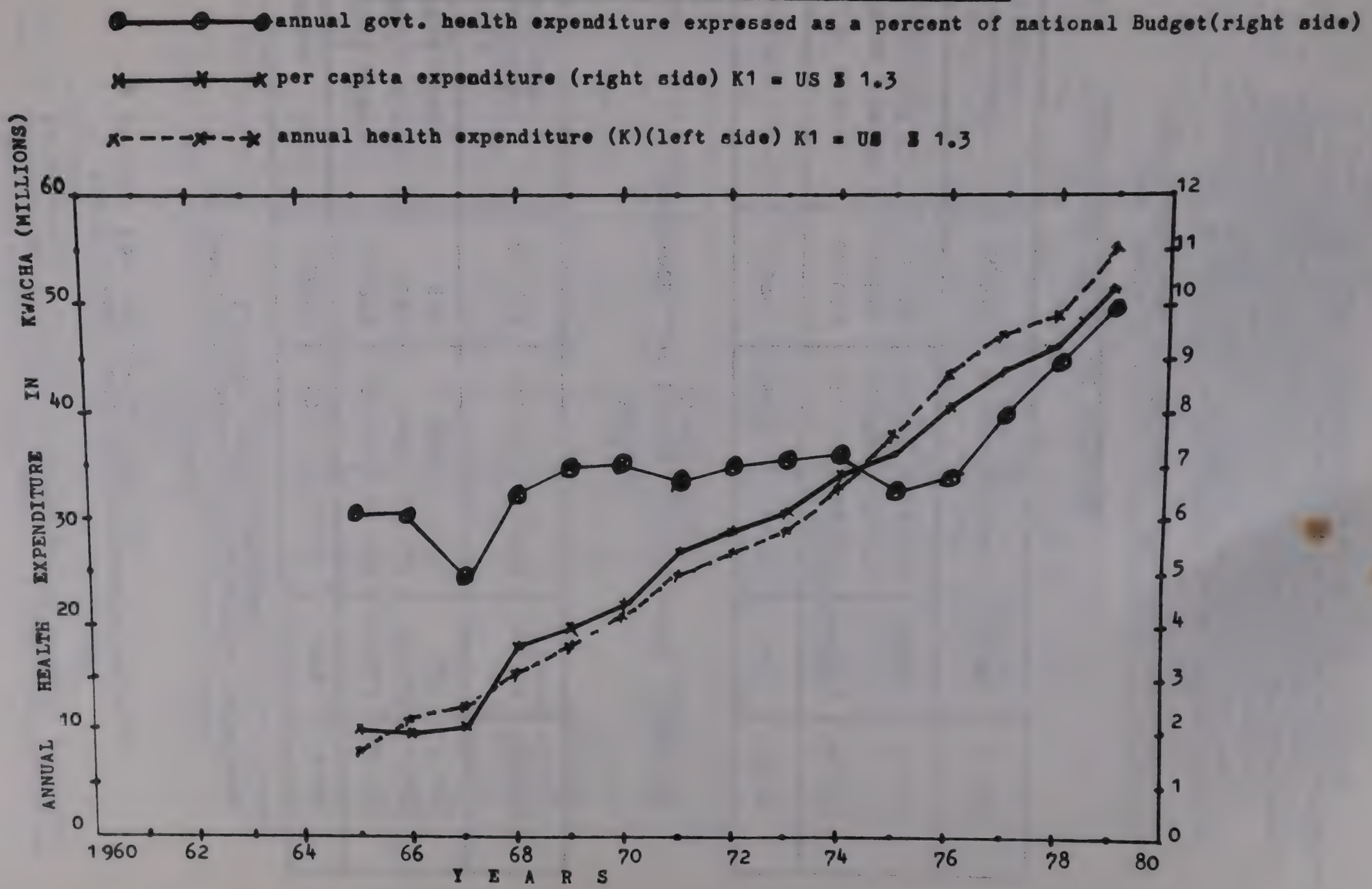
3. HEALTH RESOURCES AND SERVICES

The trends in health resources and services have been summarised in FIGURES 1 and 2 and TABLES 8 - 10.

The Government health budget clearly demonstrates increasing government concern and effort for the health of the nation. In terms of annual overall expenditure and per capital expenditure the government health budget has shown an ever increasing trend - (see FIGURE 1). The increasing expenditure is reflected in the increasing availability of health services - (see TABLE 8).

FIGURE 1

TRENDS IN GOVERNMENT ANNUAL HEALTH EXPENDITURE



TRENDS IN GROWTH OF HOSPITALS AND ADMISSIONS (EXPRESSED AS %) IN HOSPITALS AND RURAL HEALTH CENTRES (RHC)

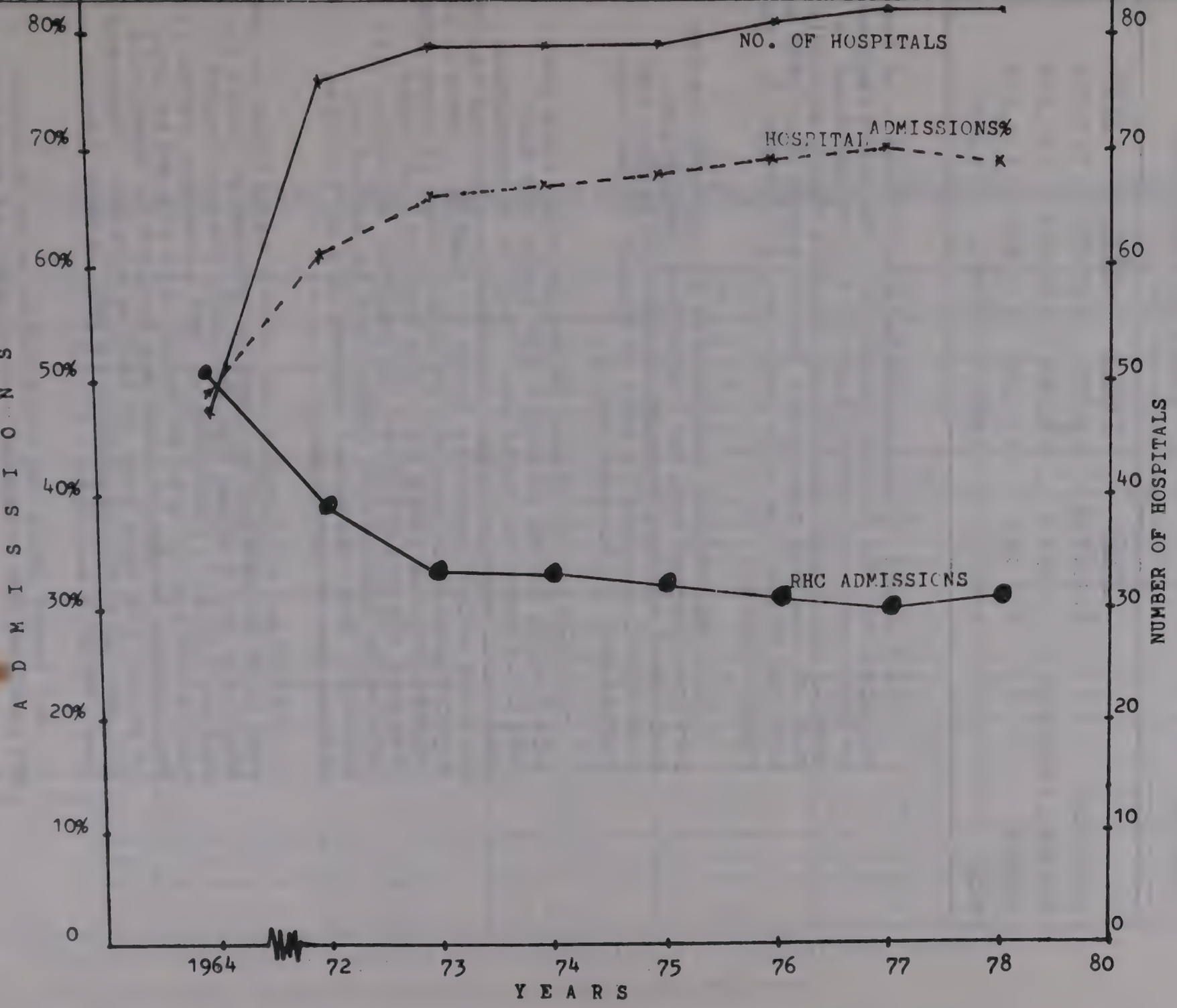


TABLE 8

PERSONNEL AND HEALTH FACILITIES - RATIOS FOR SELECTED CATEGORIES AND YEARS

CATEGORY	RATIO TO POPULATION			
	1966	1971	1977	1979
PHYSICIAN	1:11,333	1:9,500	1:7,900	1:7,800
MEDICAL ASSISTANT	N/A	1:5,447	1:5,102	1:5,200
NURSES	1:7,262	1:2,421	1:3,000	1:1,000
BEDS	1:301	1:269	1:268	1:272

The largest non-governmental contributors to heal services are the mining companies. The contribution to gross national expenditure on health services is usually approximately 50% of the government expenditu Thus whereas the government health budget for 1978 wa K49M the Mines also made budgetory allocation in the range of K20M.

This expenditure contributed to national health services through smaller Industrial facilities. Individual efforts through private surgeries and traditional healers is very difficult to estimate. Undoubtedly it is substantial.

The drastic increases in prices that have been experienced in the previous few years are most certainly going to continue. This is a tremendous constraint especially on the curative-oriented health services which presently exist in Zambia. However th major diseases of concern in Zambia have already beer identified (see TABLE 1). The majority of these diseases are preventible. By careful selection of strategies substantial reductions in mortality, morbidity and subsequent expenditure on curative efforts can be achieved.

Efficient utilization of health facilities is one area that is lacking in Zambia. Admission rates in hospitals are 5 times (16.8%) more than in health centres (3.2%). Furthermore, bed occupancy rates in health centres as well as hospitals, are quite low. The average length of stay per patient in hospitals is nearly 50% more than in health centres. Moreover the cost of hospitalisation in RHC is much lower. (see TABLES 9 and 10).

All these point to a situation of much under-utilization and uneconomic management of medical care

TABLE 9

TRENDS IN THE GROWTH AND UTILISATION OF HEALTH FACILITIES BY CATEGORIE - SELECTED YEARS

	YEAR	1964	1972	1973	1974	1975	1976	1977	1978
UNIT	RHC	306	595	612	625	631	657	665	676
	HO	48	76	79	79	79	81	82	82
	N	354	671	691	704	710	738	747	758
BEDS	RHC	3,140	4,530	4,830	4,990	5,030	5,010	5,100	51,110
	HO	7,710	12,870	13,870	13,870	14,400	14,670	14,700	15,630
	N	10,850	17,400	18,700	18,900	19,370	19,740	19,800	20,740
ADMISSIONS	RHC	158,800 (51.3%)	193,000 (39.1%)	173,800 (33.9%)	174.100 (34.7%)	172,900 (32.5%)	182,400 (31.8%)	174,900 (30.1%)	181,000 (31.8%)
	HO	150,600	302,200	339,500	328,300	360,000	392,500	405,300	388,400
	N	309,400	495,200	513,300	502,400	532,900	574,900	580,200	569,400
Average length of stay in days	RHC	7.8	6.3	6.4	6.1	6.6	6.0	5.7	6.9
	HO	12.5	10.2	9.3	9.9	8.8	9.4	9.0	9.7
	N	10.5	8.7	8.3	8.5	7.9	8.3	8.0	8.8

• RHC = Rural Health Centres; HO = Hospitals; N = National (RHC + HO)

N.B. Leprosaria, Miliatry and Mines institutions excluded.

TABLE 10

ADMISSIONS PER 100 FIRST VISITS BY YEAR AND CATEGORY

	YEAR	1964	1972	1973	1974	1975	1976	1977	1978
	R H C	158,800	193,000	173,800	174,100	172,900	182,400	174,900	181,000
ADMISSIONS	H O	150,600	302,200	339,500	328,300	360,000	392,500	405,300	388,400
	N	309,400	495,200	513,300	502,400	532,900	574,900	580,200	569,400
FIRST OPD VISIT	R H C	3,393,700	7,188,000	5,783,300	5,889,500	5,864,000	6,117,700	6,436,800	7,051,700
	H O	751,900	2,031,800	1,942,300	2,036,800	2,195,400	2,478,800	2,585,400	2,679,300
	N	4,145,600	9,219,800	7,725,600	7,926,300	8,059,400	8,596,500	9,022,200	9,731,000
ADMISSIONS FIRST VISIT	R H C	4.7	2.7	3.0	3.0	3.0	3.0	2.7	2.6
	H O	20.0	14.9	17.5	16.1	16.4	15.8	15.7	14.5
	N	7.5	5.4	6.6	6.3	6.6	6.7	6.4	5.9

4. EXCERPT FROM TNDP

"OBJECTIVES AND STRATEGY OF THE THIRD NATIONAL DEVELOPMENT PLAN 1980-1984

The general objectives for improvement of health services were spelt out in the Ten-Year National Plan 1971-80 and in the UNIP Manifesto 'National Policies for the Next Decade 1974-84'. As stated in these documents, the Party and Government's objectives aim at improving and expanding health services to cover all areas in the Republic and in doing so, continue to make the health services efficient and freely available to all people in Zambia. Further, an integrated programme of health work especially in the rural areas will be carried out through a net-work comprising basic health care; personal health services at the primary level and environmental health and sanitary facilities. These stated general objectives remain valid for the TNDP. However the strategy for the TNDP will be suitably adapted in the light of various constraints in financial manpower and material requirements experienced in the SNDP and which may be expected to continue during the TNDP period. The objectives and strategy of the TNDP are summarised as follows:-

i. Continued development of an effective and integrated national health care system.

ii. Development of basic health services in rural areas, priority being given to those areas where no such facilities exist.

iii. Attainment of higher levels of Zambianisation through expanded training programmes. During the TNDP, the distribution of health workers will be carefully examined.

iv. Movement towards complete integration and expansion of preventive and curative services.

v. Provision of health protection to an increasing number of mothers, infants, school-children and certain vulnerable categories of workers.

vi. Decentralisation of basic health services

vii. Nutritional well-being of the population, with particular reference to vulnerable groups".

What is significant at present is the reorganisation of our list of priorities. This does not constitute a departure from the statements quoted above. Zambia will embark on a new approach to health care delivery. This requires that our long and short term objectives and strategies must change appropriately.

Chapter 1.3 PRIMARY HEALTH CARE PROGRAMME - OBJECTIVE AND SERVICES

1. OVERALL OBJECTIVE

2. SERVICES TO BE PROVIDED

3. PRIMARY HEALTH CARE PROGRAMME - OBJECTIVE AND SERVICES

1. OVERALL OBJECTIVE

To make basic but essential health care accessible to all the people of Zambia.

2. SERVICES TO BE PROVIDED

Primary health care aims to tackle the main health problems of a community. Since there will be variation in the health problems from community to community the services needed to tackle them will also show some variation. However most of the services necessary to tackle the health problems in Zambia will be included under the following headings:-

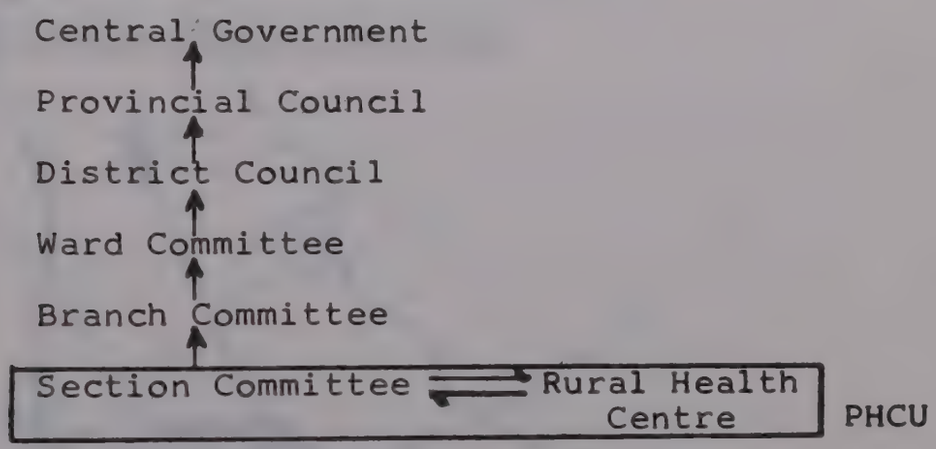
- Health Education
- Promotion of adequate nutrition and food supply
- Promotion and maintenace of a safe water supply and basic sanitation.
- Maternal and child services, including child spacing
- Immunisation
- Prevention and control of locally endemic diseases e.g. malaria, schistosomiasis, trypanosomiasis
- Promotion of mental health
- Treatment of common diseases and injuries

Chapter 2.1. ORGANISATION OF PRIMARY HEALTH CARE

1. ORGANISATION OF PRIMARY HEALTH CARE

Primary Health Care begins at the level of the community and must have the full involvement of local people in development implementation and management of the programme. Therefore, strong community organisation is essential.

The recently re-organised Party structure is well suited to community organisation and will be utilised in the development of the PHC programme (see below).



1. RURAL ORGANISATION (see Figure 3)

The Section will be the basic unit for participation by the people in the PHC programme. The views of the people will be represented by the Section Committee which may have a subsidiary Health Committee responsible for the organisation of primary health care within the village.

Where settlements or villages are small the people should be encouraged to combine under one committee.

The health centre and its villages will form a unit, the Primary Health Care Unit. Each section will have a special relationship with the health centre in whose catchment area it is situated and will receive guidance and support from the staff in developing primary health care.

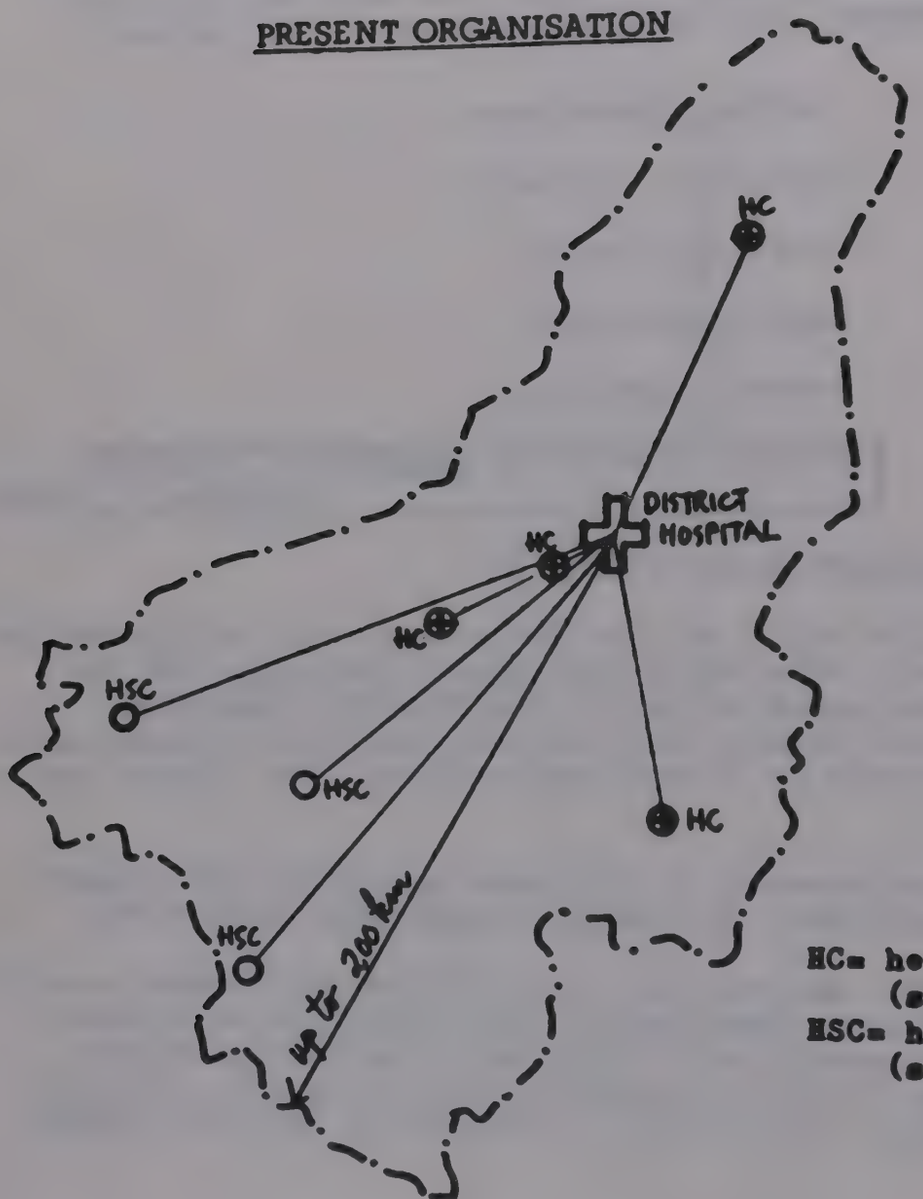
1.1 The Section

Primary Health Care in the Section will be organised by the Section Committee (or subsidiary Health Committee). A Member of the health centre staff will act as advisers to the committee.

Each Section will select a suitable member of the community to act as the primary health care worker for the Section (Community Health Worker - see paragraph 1.)

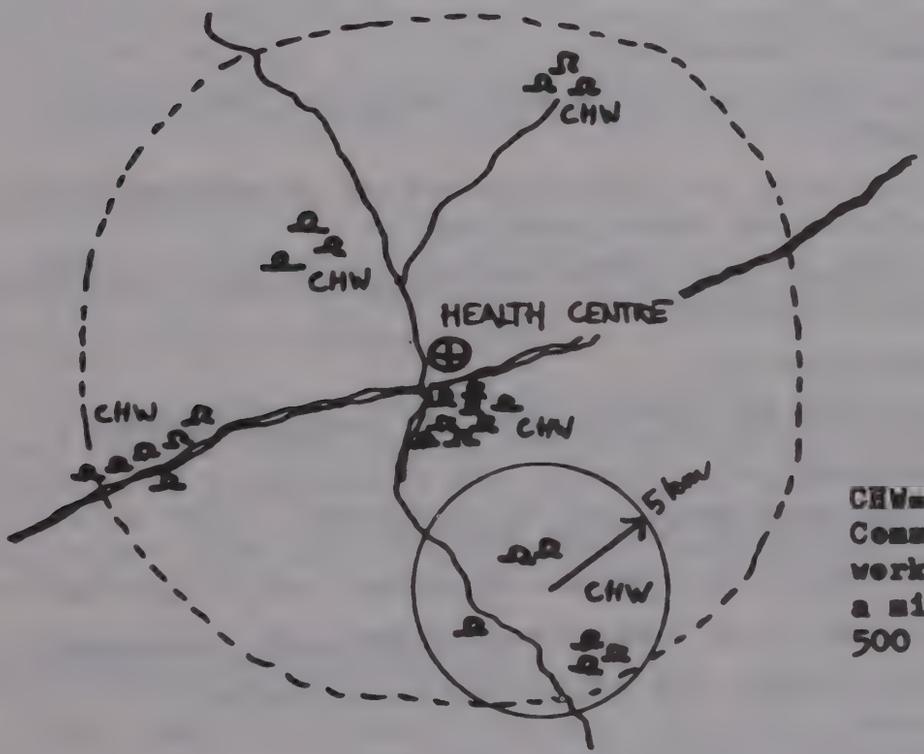
FIGURE 3

PRESENT ORGANISATION



HC= health centre (stage II)
HSC= health subcentre (stage I)

PROPOSED PRIMARY HEALTH CARE UNIT



CHW=
Community health worker serving a minimum of 500 pop.

The Community Health Worker will be responsible to the community in which they serve for carrying out PHC duties but in matters relating to guidance and treatment for specific health problems will be responsible to the health centre.

1.2 The Rural Health Centre

The staff will be responsible for management and delivery of primary health care services as well as supervision within the PHCU. Services will be provided both in the health centre and in the villages so that it will be essential for the health centre staff, including the Medical Assistant, to visit the villages regularly.

The following services will be provided:-

- Health Education
- Promotion of adequate nutrition and food supply
- Promotion and maintenance of a safe water supply and basic sanitation
- Maternal and Child Health Services, including child spacing
- Immunisation
- Prevention and control of locally endemic diseases
- Promotion of mental health
- Treatment of common diseases and injuries
- Provision of necessary drugs and equipment
- Collection and maintenance of data.

2. URBAN ORGANISATION

As in rural areas the unit of community participation will be the Section and the views of the people will be represented by the Section Committee which will be responsible for the organisation of primary health care within the Section.

Similarly the urban clinic and the Sections within its catchment area will form the Primary Health Care Unit.

2.1 The Section

Primary Health Care in the Section will be organised by the Section Committee. A representative of the clinic staff will act as adviser to the committee.

Each section will select a member of the community to be trained as the Community Health Worker. He or she will act on plans adopted by the Section Committee, and overall PHCU Committee (see below), to motivate the people and ensure maximum participation in community activities. Expert advice will be provided by clinic staff.

The duties of the urban community Health Worker will concentrate on health education and activities to promote good health. He or she will not treat patients since access to the urban clinics is much easier than to rural health centres.

2.2 The Urban Clinic

The staff under the direction of the Medical Officer or Medical Assistant will be responsible for management and delivery of primary health care services as well as supervision within the PHCU. Services will be provided both in the clinic and in the Sections and will require that clinic staff make regular visits to the community.

2.3 The PHCU Committee

Under the present system each clinic has a Committee drawn from clinic staff and a representative of each Section in the catchment area.

It is proppsed that this Committee will be re-established as the PHCU Committee with responsibility for planning and organising all primary health care activities within the PHCU. Members of the committee will continue to be drawn from the clinic staff and Section representatives.

3. THE COMMUNITY HEALTH WORKER

The Community Health Worker will be responsible for carrying out day to day PHC activities under the regular guidance and supervision of health centre staff. He or she will be responsible to the local community in carrying out an agreed programme of activities drawn up by the Section Committee with advice from health centre staff.

It must be stressed that the CHW will work WITH the commmnity rather than FOR the community. He or she will have the appropriate knowledge and skills to teach the rest of the community how to take action to prevent serious disease problems and achieve better health for themselves, their families and the community as a whole.

3.1 Selection

The Community Health Worker will be selected from within each community.

All adults in each Section should participate in the selection process which will be organised by the Section Committee (or Health Committee).

Criteria for selection should be as follows:-

- must be a mature man or woman respected and trusted by the community. A minimum age of 25 years is suggested
- must be well established in the community
- should be prepared to work on voluntary basis
- ability to read and write is desirable

3.2 Training

Training will be the responsibility of the Ministry of Health. Initial training will last for 6 weeks and will be conducted in each District at one or two health centres which have adequate staff, facilities and accommodation.

Training will equip the CHWs to perform the following tasks:-

- to give guidance on increasing food production and improving nutrition
- to promote basic sanitation and the maintenance of community sources of safe drinking water
- to detect at risk groups e.g. malnourished children
- to conduct regular home visits and give guidance on the prevention of common illnesses
- to give first aid treatment
- to diagnose and treat minor ailments and refer serious cases to the health centres
- to safely maintain and dispense some basic medicines
- to organise the community to co-operate with health centre staff in conducting community visits e.g. for immunization

- to collect and maintain simple community data

NOTE: CHWs in urban areas will not be trained to treat minor ailments due to the accessibility of urban clinics and hospitals.

3.3 Community Responsibilities

Before the selection of a CHW for training each community must be well motivated, well organised and above all, have a clear understanding about primary health care and a willingness to accept the responsibilities entailed in establishing a PHC programme in their community. Since PHC concentrates on prevention it can only be successful when people participate and take action for themselves and their families. The main role of the CHW is to guide and educate them in the ways that they can take action. Therefore the CHW must receive full support from the community.

Although it is suggested that the CHW should be a volunteer, like Party workers at Section, Branch and Ward levels, this may not always be possible. In such cases the community will be responsible for providing the means of support.

NOTE: It may be necessary to have more than one CHW in a community so that the workload may be shared. For example the Traditional Birth Attendant, with extra training, could care for women and children whilst a male CHW could carry out the remaining duties.

4. ORGANISATION AT DISTRICT LEVEL (See Figure 4)

Overall responsibility for development of PHC within each District will lie with the District Council.

Within the healthsector a District Management Team will be established to carry out planning, development, management and evaluation of PHC activities. The team will consist of the following:-

District Medical Officer - Chairman

District Primary Health Care Co-ordinator - Secretary

District Health Inspector

Principal Medical Assistant

District Public Health Nurse

District Health Education Officer

District Pharmacist

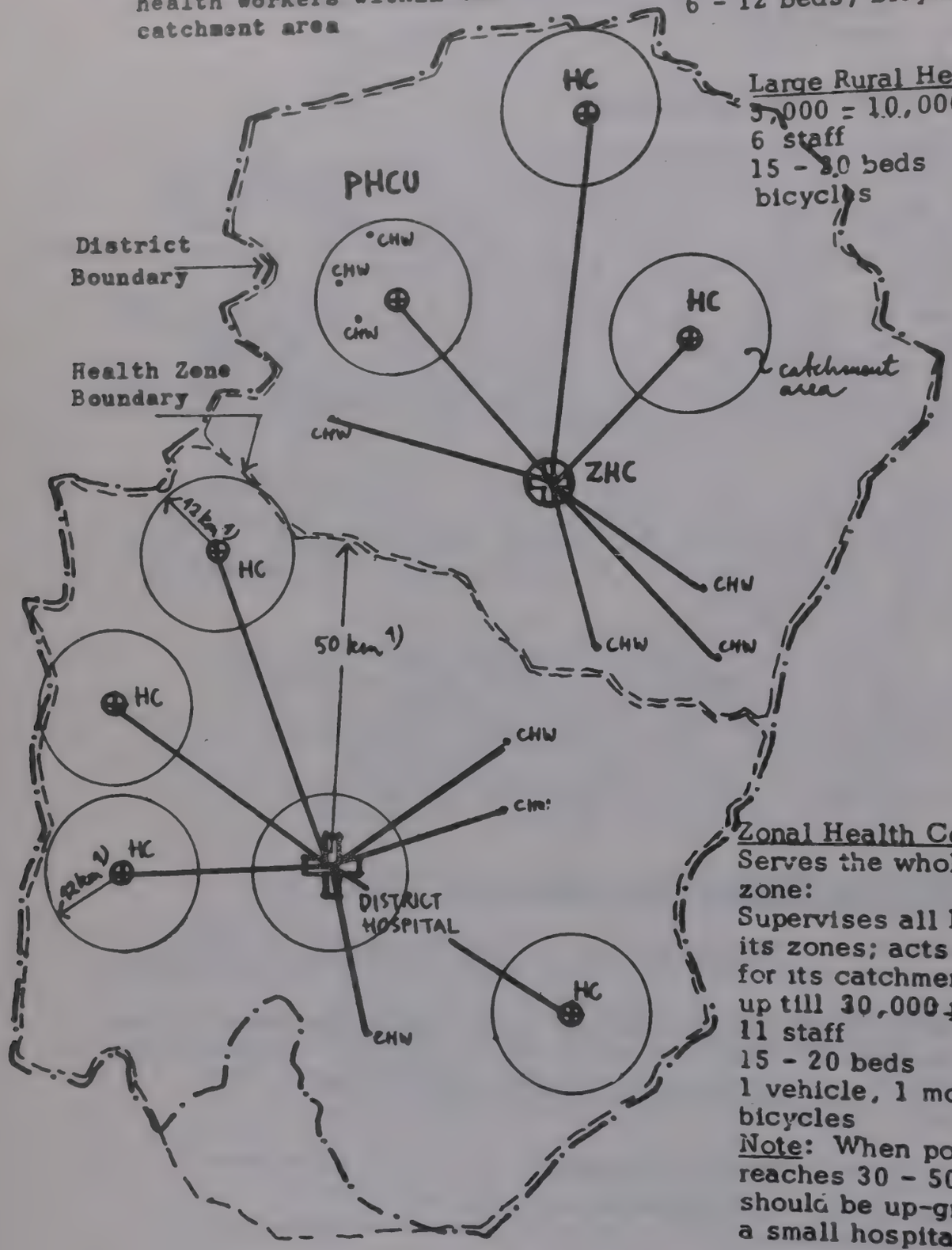
FIGURE 4

PROPOSED ORGANIZATIONAL STRUCTURE

Primary Health Care Unit= health centre + community health workers within the catchment area

Small Rural Health Centre:
2500 - 5000 pop.
3 staff
6 - 12 beds, bicycles

Large Rural Health Centre:
5,000 - 10,000 pop.
6 staff
15 - 30 beds
bicycles



Zonal Health Centre:
Serves the whole health zone:
Supervises all HC within its zones; acts as HC for its catchment areas; up till 30,000 pop.
11 staff
15 - 20 beds
1 vehicle, 1 motorbike, bicycles
Note: When population reaches 30 - 50,000 it should be up-graded to a small hospital

1) theoretical radius

District Hospital:
serves the whole district supervises all HC for its catchment area supervises all CHW outside PHCU:s in its zone small district hospital 60,000, large 100,000 pop.
50 - 70 staff
100 - 200 beds
2 vehicles, 1 motorbike, bicycles

Health Zones will be created within each District by the District Management Team. Each Zone will have a headquarters with the following responsibilities:

i. Provision of health services to people living outside PHCUs

ii. Training, supervision, and backup of Community Health Workers in villages outside PHCUs.

iii. Promotion, supervision, and evaluation of all primary health care activities within the Zone. This will be the responsibility of the Primary Health Care Co-ordinator who will be directly responsible to the District Medical Officer.

iv. Maintenance and distribution of drugs + supplies to Rural Health Centres within the Zone.

v. Serve as a referral centre for patients from within the Zone.

The Zone headquarters will be a health establishment with adequate staff and transport to fulfill the above responsibitiy. In one Zone in each District the District Hospital will be headquarters. In the other Zone the headquarters will be an upgraded Rural Health Centre, the Zonal Health Centre.

The boundaries of a Health Zone should be such that all areas within the Zone are accessible by transport from the headquarters. An area of 50Km radius around the headquarters is proposed i.e. about 2 hours drive on bush roads. Thus there will normally be 2 or 3 Health Zones in each District i.e. each with 20-50,000 inhabitants.

The boundaries of the zones should preferably coincide with District boundaries but provision should be made for exceptions where indicated by practical consideration.

Within each Zone the Primary Health Care Co-ordinator will be responsible for organisation and evaluation of primary health care as well as for staff training and public education programmes. Each Co-ordinator will be accountable to the District Medical Officer.

Primary Health Care needs considerable co-ordinated input from other sectors e.g. agriculture, education etc. At District level the District Council has an important role in this Inter-sectoral Co-operation which is fully explained in Chapter 2.3.

5. ORGANISATION AT PROVINCIAL LEVEL

Within the health sector a Provincial Management Team will be stablished to carry out planning, development, management and evaluation of PHC activities. The team will consist of the following:-

Provincial Medical Officer - Chairman
Provincial Health Education Officer - Secretary
Provincial Health Inspector
Provincial Public Health Nurse
Prinicipal Medical Assistant
Provincial Pharmacist

A Provincial Primary Health Care Co-ordinator will be added to the team whenever the District and Zonal post have been adequately staffed.

In addition the following posts will be created at Provincial level:-

- a Buildings Officer reponsible for technical advice and assistance on construction and maintenance of buildings
- a Transport Officer responsible for organisation maintenance and repair of vehicles

The Provincial Council will provide the formal mechanism for intersectoral co-operation (See chapter 2.3).

6. ORGANISATION AT CENTRAL LEVEL

The Assistant Director of Medical Services (preventive Medicine) will be redesignated as ADMS (Primary Health Care) and will be responsible for the development, implementation and evaluation of the PHC programme.

He will receive the necessary administrative and financial support from existing departments within the Ministry of Health.

Intersectoral co-operation will be planned and co-ordinated by a committee with members drawn from the Party and Senior Officers of relevant ministries. (See chapter 2.3)

Chapter 2.2 COMMUNITY PARTICIPATION IN PRIMARY HEALTH CARE

1. PREPARATION FOR COMMUNITY PARTICIPATION

2. ESTABLISHING EFFECTIVE COMMUNITY PARTICIPATION

2.1 Establishing contact with the community

2.2 Motivating the community

2.3 Making the community diagnosis

2.4 Planning the local Primary Health Care programme

3. SELF HELP PROJECTS

3.1 Proposed mechanism for planning and co-ordination of self help projects

4. PROPOSALS FOR MAINTAINING EFFECTIVE COMMUNITY PARTICIPATION

4.1 At District level

4.2 At Provincial Level

4.3 At Central level

2. COMMUNITY PARTICIPATION IN PRIMARY HEALTH CARE

The fundamental importance of community participation in planning, organisation and management of primary health care has been stressed in Chapter 1.1. It is the most effective way of achieving the goal of making primary health care accessible to all people throughout the nation.

1. PREPARATION FOR COMMUNITY PARTICIPATION

Community participation will have increased chances of success when the right conditions exist.

The following are essential prerequisites:s

- effective comunity organisation i.e. the existence of an effective Section Committee with a Community Health Worker as sits executive arm.
- an effective inter-relationship between the different organisational levels i.e. Community, District, Provincial and Central.
- motivated health centre staff
- motivated workers from related sectors.

Where these do not exist major efforts must be made to create them. This requires action in the following sequence:-

- education and orientation of health workers
- education and orientation of workers from other sectors
- education and motivation of the community and its leaders

Education should be carried out by teaching staff drawn from different disciplines. Party workers must be included in order to carry out political motivation without which effective community participation will not succeed.

Details of proposals for education are given in Chapter 2.4

2. ESTABLISHING EFFECTIVE COMMUNITY PARTICIPATION

2.1 Establishing contact with the community

It will be the duty of health centre staff to establish contact with the community, through the Section Committee.

The staff will seek to identify the extent of the community's interest in health, the overall problems of the community, and specific health problems as perceived by the people themselves.

The concepts and aims of primary health care will be explained to the Section Committee as well as its usefulness in solving the local health problems.

The purpose of this step is to gain the support and participation of the community in developing the programme.

2.2 Motivating the community

The idea of the primary health care programme should be introduced to the whole community by the Section Committee through meetings and discussions with the assistance and advice of the health centre staff.

The purpose of this step is to gain agreement and reach a decision to initiate a primary health care programme within the community.

2.3 Making the community diagnosis

The health centre staff, in consultation with the Section Committee will identify the health and health related problems of the community and list them in order of priority. The list will be used to formulate the plan of action for the community's primary health care programme.

2.4 Planning the local primary health care programme

The Section Committee with the advice of the health centre staff, will plan the primary health care programme to be implemented by the community through the Community Health Worker. Additional expertise should be provided by other workers where necessary e.g. Agricultural Assistant, Community Development Assistant, School Teacher etc.

The problems identified during the community diagnosis will be used to formulate the objectives and priorities for the primary health care programme.

Further development of plans must include a thorough assessment of the resources which the community can provide to ensure successful im plementation of projects. Resources include manpower (labour),materials e.g. bricks for building, and money.

Assessment of resources must be carried out BEFORE implementation commences to avoid delays due to unforeseen shortages.

3. SELF HELP PROJECTS

Self help projects in the field of health are already widespread in Zambia. The term 'self help' implies that a comunity takes complete responsibility for a project from planning through to implementation, including provision of all resources. In practice resources such as building materials and other equipment are often obtained from outside sources such as District or Provincial authorities.

Experience has shown that implementation of such projects can be considerably improved, principally by better PLANNING.

Even where a project has been undertaken solely by a community without external help there may be subsequent implications which require some action by District or Provincial authorities.

One example is the contruction of a self help clinic. The community will expect that the clinic will be staffed by trained health workers, usually provided by the Ministry of Health. In such a case it is clear that the staff must have responsibility for providing health care to a much wider population than the local community if, as part of the nation's manpower, they are to be deployed effectively. The accepted area of responsibility lies within a 12km. radius of a health centre (see Chapter 2.6).

Therefore, it is essential that the DMO and PMO should be consulted whenever such a project is proposed so that a clinic can be sited in an appropriate position and preparation made to provide staff when the building is completed.

There must be effective CO-ORDINATION between Section Committees and District or Provincial authorities whenever self help projects are proposed.

Co-ordination may also involve sectors other than health. For example, if a community decides to tackle the problem of malnutrition there will be a need to seek assistance from representatives from the Ministry of Agriculture and Water Development and the Department of Community Development.

Thus proposals for a community project must be communicated to the appropriate District and Provincial authorities together with requests for specific assistance. Thereafter appropriate co-ordination can be established between the Section Committee and the sectors involved.

3.1 Mechanism for planning and co-ordination of self help projects

3.1.1 It must be clearly understood that in the health context self help refers to any community action with the aim of improving health. Thus the construction of a clinic is only one possibility. Other possibilities include improvement of housing, improvement and maintenance of existing health facilities, the construction and maintenance of safe drinking water wells and bore-holes and the construction and maintenance of sanitary excreta and waste disposal facilities.

3.1.2 A self help project must derive from the community's expressed desire to undertake it in the full knowledge of their responsibilities and the ability of the Ministry of Health to respond.

3.1.3 When a community wishes to carry out a self help project the Section Committee will notify the Ward and District Councils in order to discuss the proposed project.

3.1.4 The District Council will notify appropriate District Officers e.g. DMO, DAO so that technical personnel can meet with the Section Committee to discuss proposals in detail, advise on viability of the project, assist in preparing detailed plans and establish necessary co-ordination.

3.1.5 The District Officers will communicate with their provincial counterparts to request technical advice, materials or funds. In the case of self help clinics it is essential that the Provincial Health Inspector and the Principal Health Assistant in charge of the Provincial Building Team be contacted early for their technical guidance.

When a project is judged to be viable it is of paramount importance that the community's enthusiasm is maintained. Where a project is clearly unrealistic efforts must be made to persuade the community to divert their efforts to another project where there is an agreed need.

4. PROPOSALS FOR MAINTAINING EFFECTIVE COMMUNITY PARTICIPATION

4.1 At District level

The Primary Health Care Co-ordinator for each Health Zone will be responsible for community participation within the Zone. His duties will entail meetings and discussions with Section Committees, health centre staff and personnel from other sectors to ensure good co-ordination in PHC activities and to give guidance on making community participation as effective as possible. This will include directing the Section Committee to the appropriate officers at District or Provincial level whenever technical assistance or provision of materials are required.

4.2 At Provincial Level

The Provincial Health Education Officer will be responsible for community participation in primary health care throughout the Province. His duties will include dissemination of information and guidance about primary health care and community participation as well as organisation of training programmes for staff and community leaders.

This responsibility will be reviewed at the time of creation of the post of Provincial Primary Health Care Co-ordinator.

4.3 At Central level

The PHC Section of the Ministry of Health will monitor community participation in primary health care throughout the country and will disseminate information and guidance to the Provinces and Districts.

Technical assistance on all aspects of design, construction and maintenance in self help building projects will be provided the Ministry of Health Planning Unit.

Chapter 2.3 INTERSECTORAL CO-OPERATION

3. INTERSECTORAL CO-OPERATION

1. BACKGROUND

Primary Health Care is an integral part of the soci-economic development process. If it is to succeed it will require the support of the rest of the health system and of other relevant social and economic sectors.

Health system support includes facilities for consultation on health problems, referral of patients to local and more specialised health institutions, and provision of supportive supervision and guidance, logistic support and supplies.

In other sectors particular support will be required from such sectors as agriculture, water development, nutrition, education, community development, information and broadcasting.

Although it has already been mentioned in the introduction it is worth emphasising again the importance of support and participation by the Party at all levels. Experience from other countries has shown that enthusiastic political leadership of the programme is a prerequisite for successful introduction of PHC.

For support to be effective it must be well co-ordinated not just at the local or community level but at intermediate and national levels as well.

Health services by themselves have a limited impact on overall development of the health of the nation. The combined effect of other sectors is much greater.

However, the effect can be negative as well as positive. For example agricultural policy may encourage production of crops for sale while failing to safeguard food supplies for the actual producers. Irrigation schemes may create ideal conditions for the breeding of mosquitos with a subsequent increase in malaria. Industrial development can contribute to a drift by the population from rural to urban areas resulting in unemployment and poverty. Pollution of the environment by toxic chemicals may also result.

In order to eradicate these negative effects and build a healthy nation co-operation between different sectors is an absolute necessity.

2. MECHANISMS FOR INTERSECTORAL CO-OPERATION

As mentioned in the introduction the need for intersectoral cooperation and coordination has been clearly recognised in Zambia since the time of independence. Equally the need for participation by the people in their own development has been continually stressed. Indeed much of the aims and content of PHC is already embodied in the constitution of the Party.

Similarly mechanisms for putting intersectoral cooperation into action have already been established.

It is proposed that existing mechanisms should be utilised as follows:-

2.1 At Community level

The Section Committee will take responsibility for intersectoral cooperation at community level. It will be responsible to the Ward Council.

Where these committees are not working well they will need to be stimulated by a combination of local political activity and motivation by the PHC Co-ordinator.

2.2 At District level

The District Council will be responsible for intersectoral cooperation in planning PHC activities within the District.

2.3. At Provincial Level

The Provincial Council will be responsible for intersectoral cooperation in planning PHC activities within the Province.

The decentralisation of local government soon to be introduced by the Party and its Government will greatly benefit the development of primary health care through improved local planning and decision making. In addition the new District Councils will form an excellent mechanism for effective intersectoral co-operation.

2.4 At Central level

Intersectoral co-operation will be planned and co-ordinated by a committee with membership drawn from the Party and senior officers of relevant Ministries. The Ministry of Health will be represented by the Assistant Director of Medical Services (Primary Health Care) and the PHC section of the Ministry will provide the secretariat to service the committee.

3. EXISTING MECHANISM FOR INTERSECTORAL CO-OPERATION

At central level a number of groups have already been established to co-ordinated certain PHC activities. These are:-

3.1 The Co-ordinating Committee for Communications and Health Information (see Chapter 4).

3.2 The National Appropriate Technology Committee

3.3 The National Action Committee for the International Drinking Water and Sanitation Decade.

4. INTERSECTORAL PROGRAMMES IN PHC

4.1 Water and Sanitation

Thus far the most important intersectoral programme in PHC is the International Drinking Water Supply and Sanitation Decade the objective of which is to assist governments to accelerate their plans to achieve the adopted global goal of access to safe water and adequate sanitation by the year 1990.

Preliminary studies have shown that Zambia has an abudance of both surface and underground water resources. However, there are constraints which prevent the effective use of these resources. These are poor sanitation facilities which inevitably lead to the contamination of water supplies, unprotected drinking water sources such as wells and springs, the lack of appropriate designs of pumps and latrines suitable for local conditions, the lack of trained manpower to operate water and sanitation facilities and the lack of coordination between bodies responsible for water supply and sanitation.

Unsafe water plays a central role in the spread of some communicable diseases such as diarrhoeal disorders, cholera, typhoid and schistosomiasis. Statistics show that 10 percent of inpatient admissions and 11 percent of deaths in hospitals are due to diarrhoeal disease. Infants and young children are particularly seriously affected.

In Zambia it has been estimated that 19 percent of the households in urban areas and more than 50 percent in rural areas do not have access to safe water.

A National Action Committee (see para 3.3) has already been established to prepare a detailed programme for the Decade and to co-ordinate implementation. The nucleus of the committee is drawn from the National Commission for Development Planning.

the Department of Water Affairs and the Ministry of Health.

The people of the rural areas being in greatest need the programe will give top priority to the provision of safe drinking water and sanitation to the rural population. Subsequent efforts will concentrate on meeting the needs of the rural and urban townships and the towns and cities.

Priority will be given to the upgrading and repair of existing wells, well points and boreholes, many of which are in disrepair and contaminated.

Where no facilities exist new wells, well points and boreholes will be constructed and where possible protected by hand pumps of an appropriate and easily maintained design.

Construction of sanitary facilities will be developed in co-ordination with the development of water supply.

In order to achieve lasting benefit communities will be involved in the planning, construction and maintenance of their water and sanitation facilities wherever appropriate. For this to take place effectively health education will form an important part of the programme and will be a major part of the CHW's responsibilities.

4.2 Appropriate Technology

PHC stresses community participation and the active cooperation of those sectors which have an impact on health. An important part of this activity must be development of simple, low cost techniques and equipment to be used in assisting people in their PHC programme. Materials must be locally available and the end product must be acceptable to people. Only then can this innovation technology be considered appropriate.

Several good examples have already been developed in Zambia. These are:-

- a fetal stethoscope made from local clay, developed in Northern Province for use by TBAs by Mrs. Christine Nkole.
- a pest proff granary developed at the Mt. Makulu Research Centre in Chilanga.
- a supplementary weaning food, Nutrifex, developed by the National Council for Scientific Reseach and the National Food and Nutrition Commission.

Many other examples exist in other countries are easily adaptable to Zambian conditions. Examples include water and grain storage containers, water pumps, grain drying equipment and water heaters using solar energy, harvesting equipment, building materials and techniques for low cost housing.

A National Appropriate Technology Committee has been established (see para 3.2) to promote interest in appropriate technology, to compile information on existing activities in Zambia and to support the development of important appropriate technology projects. The committee has representatives from many government ministries. including Health as well as the University of Zambia, Zambia Council for Social Development and FAO.

5. FURTHER DEVELOPMENT OF INTERSECTORAL CO-OPERATION

The preceding sections 3 and 4 have reported on intersectoral mechanisms which have been established since proposals for PHC in Zambia were first published. However, these are insufficient and further co-operation is required.

The Ministry of Health considers the following proposals to be of particular importance:-

5.1 Education

Education, like health is an essential component of socio-economic development. Healthy children learn well so it is the duty of the nation to ensure that school children achieve the highest possible level of health.

PROPOSALS

5.1.1 Health Education

The Ministry of Education and Ministry of Health will increase their existing cooperation to ensure improvement in the teaching of health education in schools. In particular it is important that teaching should equip children with the khowledge and skills to take positive action for improved PHC for their families, and the community. Participation by schools in local PHC projects will be especially useful in this respect.

It is further proposed that training in health education and PHC should form an important part of the curriculum in teacher training colleges.

5.1.2 Training of School teachers

School teachers will be trained to monitor the health of the children, maintain a healthy environment in the school and provide simple treatment and First Aid when necessary.

Training will be undertaken by the Ministry of Health.

This proposals has been put into effect on an experimental basis in 18 schools in Central Province and, thus far, has proved highly successful.

5.2 Communications

The introduction of a telex system in the Provincial Provincial Medical Officer's office as a means of improving the procedure for the requisition of drugs from the Ministry of Health Headquarters has already been proposed in Chapter 2.8. However, this is just one example of the benefits of an effective communications system.

In order to ensure an effective PHC Programme there will be a need for good communication between the CHW and health centre staff and between health centres and Zonal and District Headquarters. For example there may be a need to request supplies of medicines or advice about a seriously ill patient. Alternatively it may be necessary to alert health workers about the outbreak of an epidemic. Often the need will be just to make regular routine contact to maintain morale and avoid the demoralising effects of isolation.

Proposals

It is proposed that the Posts and Telecommunications Corporation and the Ministry of Health, though its Planning Unit, will undertake to investigate the extent of the existing communications system and how it may be utilised to provide effective communications for PHC. The study will include telephone, radio and telex systems. The feasibility of extending these systems will also form part of the investigation.

6. NON-GOVERNMENT ORGANISATIONS

It is expected that non-government organisations will play a full part in the primary health care programme. The organisations concerned are:-

- the Church Health agencies
- the Industrial Sector
- private and voluntary agencies e.g. private medical practitioners, Red Cross etc.

It is well known that these organisations already make major contributions to the nation's health system. The Church is already involved in a number of PHC projects and reports from industry, particularly the Mines, indicate that some of their medical work could be classified under PHC.

However, the Ministry of Health believes that more progress could be made through improved communications and co-operation where appropriate.

Proposals

Copies of this document will be forwarded to non government organisations involved in health care. In light of the plans for the national PHC system it is proposed that each organisation will draw up plans for participation and forward copies to the Planning Unit, Ministry of Health.

Chapter 2.4 COMMUNICATIONS AND HEALTH EDUCATION

1. INTRODUCTION

2. AIMS

3. MECHANISM

3.1 PHC Communications Co-ordination Committee

3.2 Training

3.3 Public Education

3.4 Manpower Development

4. RESEARCH AND EVALUATION

4. COMMUNICATIONS AND HEALTH EDUCATION

1. INTRODUCTION

The primary health care approach is largely preventive in nature. Therefore, the Community Health Worker will spend the majority of his time organizing educating and motivating people to take the necessary action to improve and maintain their own health. Health education is defined as the process by which the health related knowledge, attitudes and behaviour of individuals and groups are changed and their health status improved by their own actions.

Earlier it has been stressed that community participation is absolutely essential for the realization of primary health (PHC) objectives. However, the community will only be able to participate meaningfully and effectively if it is properly informed, trained and organised. The major role of health education is to carry out these and other essential functions which are outlined below.

For these reasons health education will be a high priority in the implementation of the PHC programme.

2. AIMS

The aims of the Health Education component of the PHC programme are as follows:-

i. Train staff from all sectors to contribute to the planning, implementation and evaluation of PHC.

ii. Educate specific individuals and groups on the relevance of PHC in achieving personal, community and national development goals.

iii. Promote community participation in the P.H.C. programme.

iv. Establish and maintain effective channels of communication between the community, PHC workers and personnel from the health and other sectors.

v. Evaluate all aspects of the educational component.

vi. Initiate and conduct research leading to the development of more effective methods to use in the educational and communication processes.

3. MECHANISM FOR IMPLEMENTATION

3.1 The PHC Communications Co-ordination Committee

The National PHC Conference recommended the setting up of a PHC Communications Co-ordination Committee so that manpower, equipment and technical knowledge can be shared among ministries thus maximising available resources.
This Committee has been established and will continue to function.

Membership is drawn from the Ministries of Health, Education, Agriculture and Water Development, and Information and Broadcasting, as well as the National Food and Nutrition Commission and the Department of Community Development.

3.1.1 FUNCTIONS

The functions of the committee are as follows:-

- the production of health education materials directed at the general public
- the production of training materials for health and other extension workers
- the production of radio programes
- the production of a regular health information bulletin and materials for the national mass media

Similar committees will be established at Provincial and District levels.

3.2 Training

Training will be one of the major activities in the implementation of the PHC programme particularly during the years 1981 - 85. Activities will concentrate on the following:-

3.2.1 Orientation of teaching in the health sector training schools towards PHC

3.2.2 Production of training materials for health staff, personnel from other sectors, community leaders and CHWs.

3.2.3 Training of trainers who will conduct inservice PHC workshops for personnel in 3.2.2 above.

3.2.4 Conducting of inservice PHC workshops to orientate and train personnel for their roles in the development of PHC and to help them develop skills in communicating with the public.

3.2.5 Training of CHWs.

3.3 PUBLIC EDUCATION

All available channels of communication will be used to make the public more aware of the PHC programme and the role they can play in achieving better health. It is intended to make use of the mass media, traditional media and institutions such as schools, teacher training colleges and functional literacy groups.

Regular radio programmes will be produced in English and the major languages to inform the general public.

Pamphlets posters and audio-visual materials on PHC will be produced for training and educational purposes.

A PHC Health Information Bulletin will be published and distributed every 2 months.

At community level appropriate methods of communicating PHC information will be encouraged. Examples are traditonal dance and drama performances, village noticeboards for posters and simple written information, and regular village and section meetings.

3.4 MANPOWER DEVELOPMENT

The present number of trained health education staff is inadequate.

3.4.1 In the Health Education Unit existing staff will be redesignated to take responsibilities for communications co-ordination, training, materials development and research/pre testing of materials. In addition a radio specialist and graphic artist/photographer will be employed.

3.4.2 Additional trained Health Education Officers will be deployed so that there will be one in each Province and at the Health Demonstration Zone. These officers will be supplied with a duplicating machine and sufficient stationery to enable them to produce educational materials in the local languages.

4. RESEARCH AND EVALUATION

4.1 Since health education materials are designed to have an impact at community level it is essential that proper research be carried out at community level in order to obtain adequate information.

4.1.1 The Health Education Unit and the Reseacher/ pre tester will conduct such research.

4.1.2 Collaboration with other research institutions such as the University of Zambia will be promoted.

4.2 The Health Education Unit and Provincial Health Education Officers will routinely evaluate all aspects of the health education component of the PHC programe.

Chapter 2.5 MANPOWER REQUIREMENTS FOR PRIMARY HEALTH CARE

5. MANPOWER REQUIREMENTS FOR PHC

The adequate provision of trained personnel and their effective deployment are crucial for the development of the PHC programme in Zambia.

PHC aims to make basic health care available to all the people where they live and the proposals for achieving this objective have been outlined in the preceding chapters. PHC also gives priority to areas of greatest need. It is clear, therefore, that development of PHC in the rural areas is the foremost requirement. Chapter 2.6 details the requirements for health centre development as a means of meeting the needs of the rural population. However, health centres require proper staffing if they are to function effectively. In addition adequate back up staff are required to provide training and supervision drugs and equipment and referral services for diagnosis and treatment of patients who cannot be cared for at health centre level.

1. PRESENT SITUATION

The table below shows the present shortfall in the 3 cadres most important for PHC i.e. the Medical Assistant Health Assistant and ZEN/ZEM.

TABLE 11

	Nos. needed now	Nos. available	Shortfall
Medical Assistant	1404	1268	136
Health Assistant	580	395	185
ZEN/ZEM	3548		1398

The number available and numbers needed are for all institutions i.e. hospitals as well as health centres. Thus the shortfalls are also for all institutions.

Crude Birth Rate	50 per 1000 population
Still births	25 per 1000 live births
Perinatal mortality	50 per 1000 live births
Infant Mortality Rate	140 per 1000 live births
Deaths between 1 & 4.9 years	70 per 1000 live births
Crude Death Rate	19 per 1000 population
Morbidity Rate estimated at 3 to 4 times Crude Death Rate.	

3.2 Estimates of minimum staffing levels

For the PHC programe to develop succeessfully the immediate manpower need will be to provide an adequate level of staffing at existing health centres, at new health centres as they are completed, at Zonal health centres and the District Hospitals. For this reason the document has concentrated on the fulfillment of MINIMUM requirements as the first essential manpower goal.

A minimum staffing requirement was calculated for each level using the **estimated** workload and the services to be provided. The minimum estimated requirements were as follows:-

Village level	1 Community Health Worker	
Small RHC (StageI)	Medical Assistant	1
	Health "	1
	ZEN/ZEM	1
	Total	3
Large RHC (Stage II)	Medical Assistants	2
	Health "	1
	ZEN/ZEM	2
	Total	5

Zonal Health Centre

PHC Co-ordinator	1
Principal or Senior Med. Asst.	1
Medical Assistants	2
Medical Assistant Psychiatry	1
ZEN (preferably males)	2
ZEM	2
Enrolled Psychiatric Nurse	1
Senior Health Assistant	1
Lab. Assistant	1
Nutrition Demonstrator	1
Total	13

District Hospitals

These can be subdivided into small(serving approximately 60,000 people) and large (serving approximately 90,000). In Zambia $\frac{2}{3}$ of District Hospitals are small and $\frac{1}{3}$ large.

The staffing of District Hospitals listed in this chapter includes District Medical Officer and his team, staff required to provide health care in areas where there is no health centre, staff providing health centre facilities for the local population as well as the staff providing clinical back-up services for the whole District. The District Medical Officer will be a Public Health specialist and will head the District Management Team.

TABLE 12

STAFF CATEGORY	SMALL D. HOSPITAL	LARGE D. HOSPITAL
Public Health Specialist	1	1
Medical Officers	3	5
Pharmacists	1	1
ZRN/Midwives	3	5
Public Health Nurse	-	1
PHC Co-ordinators	1	1
Psych. Nurses	1	2
Medical Assistants	4	5
Med. Ass. Psych.	2	2
Med. Asst. Anaesth.	1	1
ZEN/ZEM	20	30
Health Inspectors	2	2
Health Assistants	1	1
Lab. Technicians	2	2
Lab. Assistants	1	1
Radiographers	1	1
X-ray Assistants	1	1
Dental Assistants	1	1
Pharm. Technicians	2	2
Hosp. Administrator	1	1
Dentist	-	1
Pyhsiotherapist	-	1
TOTAL	49	67

3.3 Calculation of National requirements 1980-90

National manpower requirements over the period 1980-90 were calculated using the following criteria.

- Estimates to meet minimum requirements at the levels metioned above.
- Requirements to fill proposed new institutions (see TABLE 13 below).
- Drain from each cadre due to retirement of entry into speciality or private sector e.g. mines.

TABLE 13

PLANNING FOR NEW HEALTH ESTABLISHMENTS

YEAR	Pop. INCREASE OVER 1979	No. OF EXTRA HOSPITALS		No. OF EXTRA HEALTH CENTRES
		Large	Small	
1981	378,000	1	2	35
1983	788,000	2	4	80
1985	1,193,000	3	6	120
1987	1,623,000	4	8	160
1989	2,021,000	5	10	200
TOTAL	2,021,000	5	10	200

1. Health Centres - It is desirable to plan that for every 10,000 population increase during the next 10 years we provide a new health centre. This will mean building 200 new centres.

2. District Hospitals - For every 100,000 population increase we should build a new district hospital; this would mean building 20 new District Hospitals. This is not feasible taking the present financial constraint. Therefore we should plan to build 5 new large district hospitals in five of the seven districts presently without a district hospital. Then we should upgrade 10 large Health centres into small district hospitals during the period i.e. 5 large + 10 small = 15 District hospitals.

4. MANPOWER DEVELOPMENT PLAN

These plans are based on the needs in order to achieve Zambianisation in all staff categories. Zambians should be filling 80 - 90 per cent of posts in most categories by 1990.

A period of rural service will be mandatory for health personnel to ensure proper filling of posts.

Staff projections in cadres most relevant to PHC are set out in TABLE 14. The accompanying graphs illustrate the total requirements, the numbers available if present trends continue and the numbers available if the proposals are complied with.

4.1 Medical Assistants

At present the annual loss due to retirements and specialist training exceeds the annual intake.

The annual intake will be doubled to 160 from 1981. This will require addition training facilities and staff and may require the construction of a new school.

4.2 Health Assistants

It is proposed to increase the annual intake of 50 to between 70 and 80 from 1982.

4.3 Enrolled Nurses

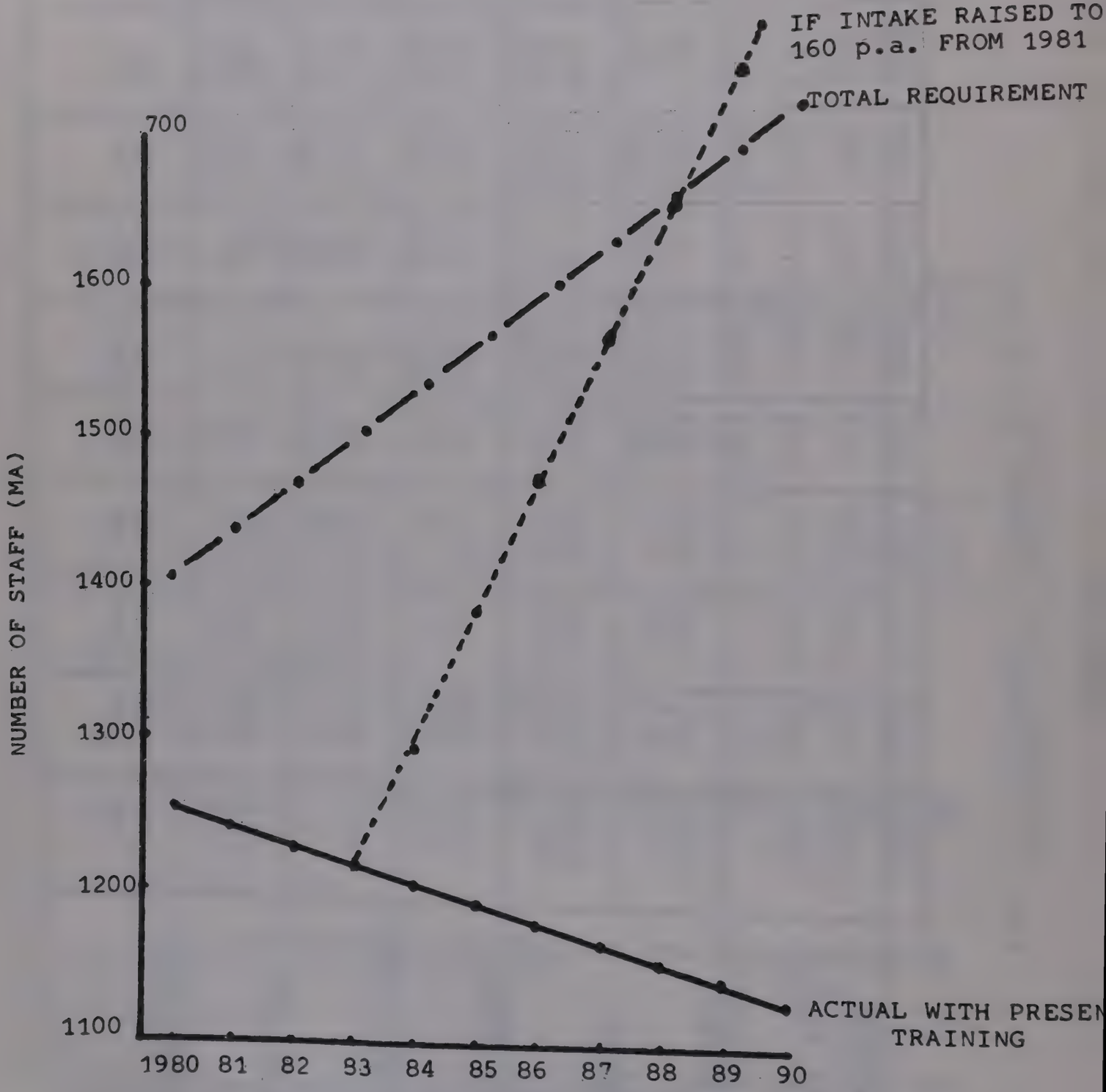
The present schools output plus the output from the planned 6 new schools will provide adequate numbers of nurses. Indeed by 1990 there may be an excess of some 720 above the requirements. ZENs will be encouraged to do midwifery training to qualify as ZEMs.

TABLE 14

SUMMARISED STAFF PROJECTIONS
(This is reproduced in accompanying graphs)

	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990
MEDICAL ASSISTANTS											
(a) Total Requirements	1404	1428	1456	1428	1508	1535	1562	1589	1616	1643	1670
(b) Present Staff output and minus loss from Cadre	1255	1242	1229	1216	1203	1190	1177	1164	1151	1138	1125
(c) If output increased					1295	1374	1453	1532	1611	1690	1769
HEALTH ASSISTANTS											
(a)	580	602	624	646	668	690	712	734	756	778	800
(b)	426	457	488	519	550	581	612	643	674	705	736
(c)					570	621	672	723	774	825	876
ENROLLED NURSES											
(a)	3548	3603	3658	3713	3788	3823	3878	3933	3988	4043	4098
(b)	2380	2610	2840	3070	3300	3530	3760	3990	4220	4450	4680
(c)						3630	3960	4290	4620	4950	5280
HEALTH INSPECTORS											
(a)	205	208	211	214	217	220	223	226	230	234	240
(b)	144	153	162	171	180	189	198	207	216	225	234
(c)						195	210	225	240	255	270
LABORATORY ASSISTANTS											
(a)	355	374	393	417	441	463	485	507	529	551	573
(b)	97	112	127	142	157	172	187	192	207	222	237
(c)					193	245	297	349	401	453	505
DOCTOR/SPECIALISTS											
(a)	597	628	659	690	721	752	783	814	845	876	905
(b)	134	167	200	233	280	327	374	421	468	515	562
								469	564	659	754
PHARMACEUTICAL TECH.											
(a)	179	187	195	203	211	219	227	235	241	249	257
(b)	131	147	169	190	212	234	256	278	300	321	343
(c)											

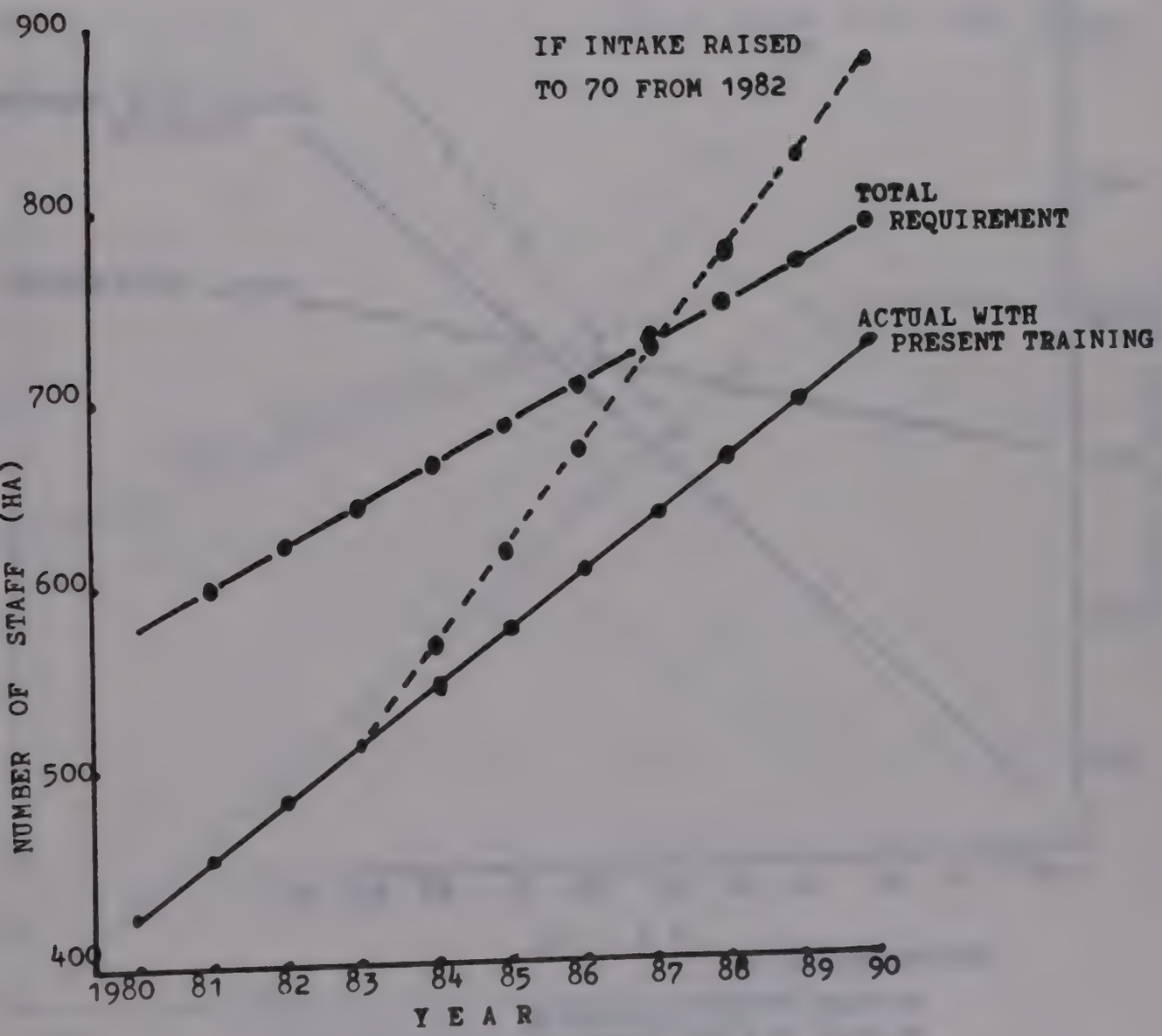
GRAPH 1 MEDICAL ASSISTANTS (MA)



RECOMMENDATION:-

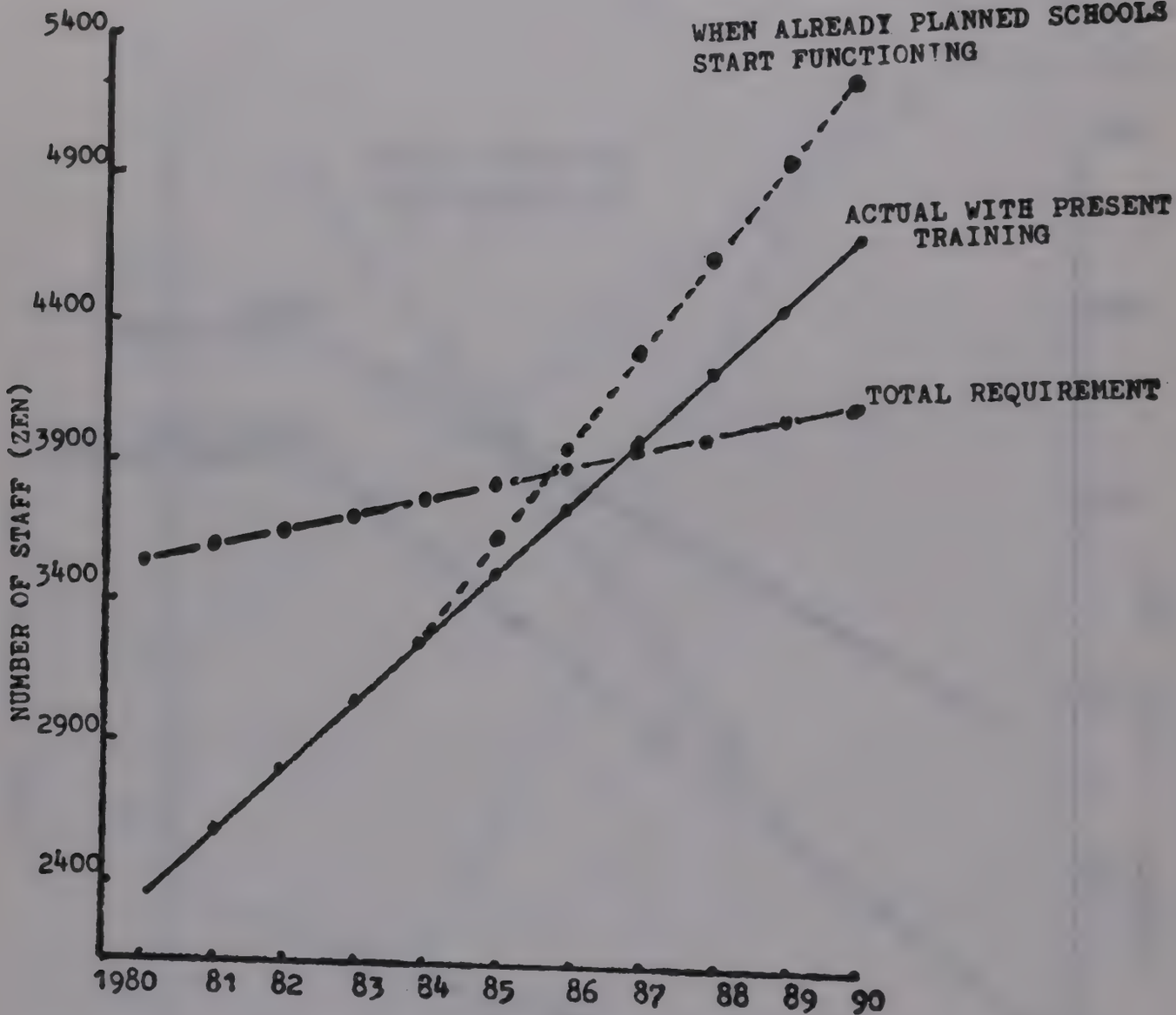
DOUBLE INTAKE TO 160 FROM 1981

GRAPH 2 HEALTH ASSISTANTS (HA)



RECOMMENDATION :-
INCREASE INTAKE BY 20 TO 70 1982

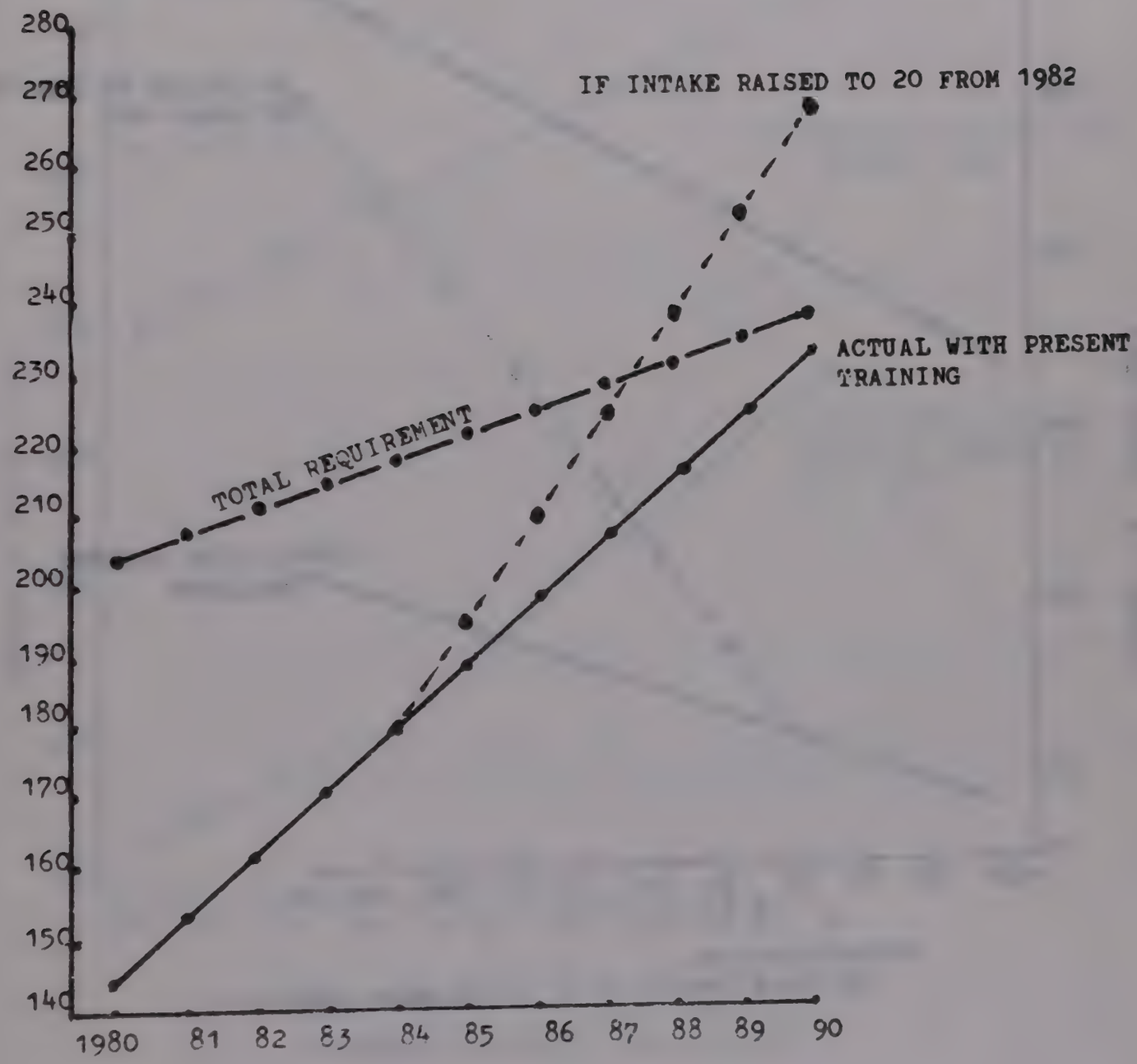
GRAPH 3 ENROLLED NURSES (ZEN)



RECOMMENDATION:-

PRESENT SCHOOLS ADEQUATE
NO NEED FOR NEW SCHOOLS

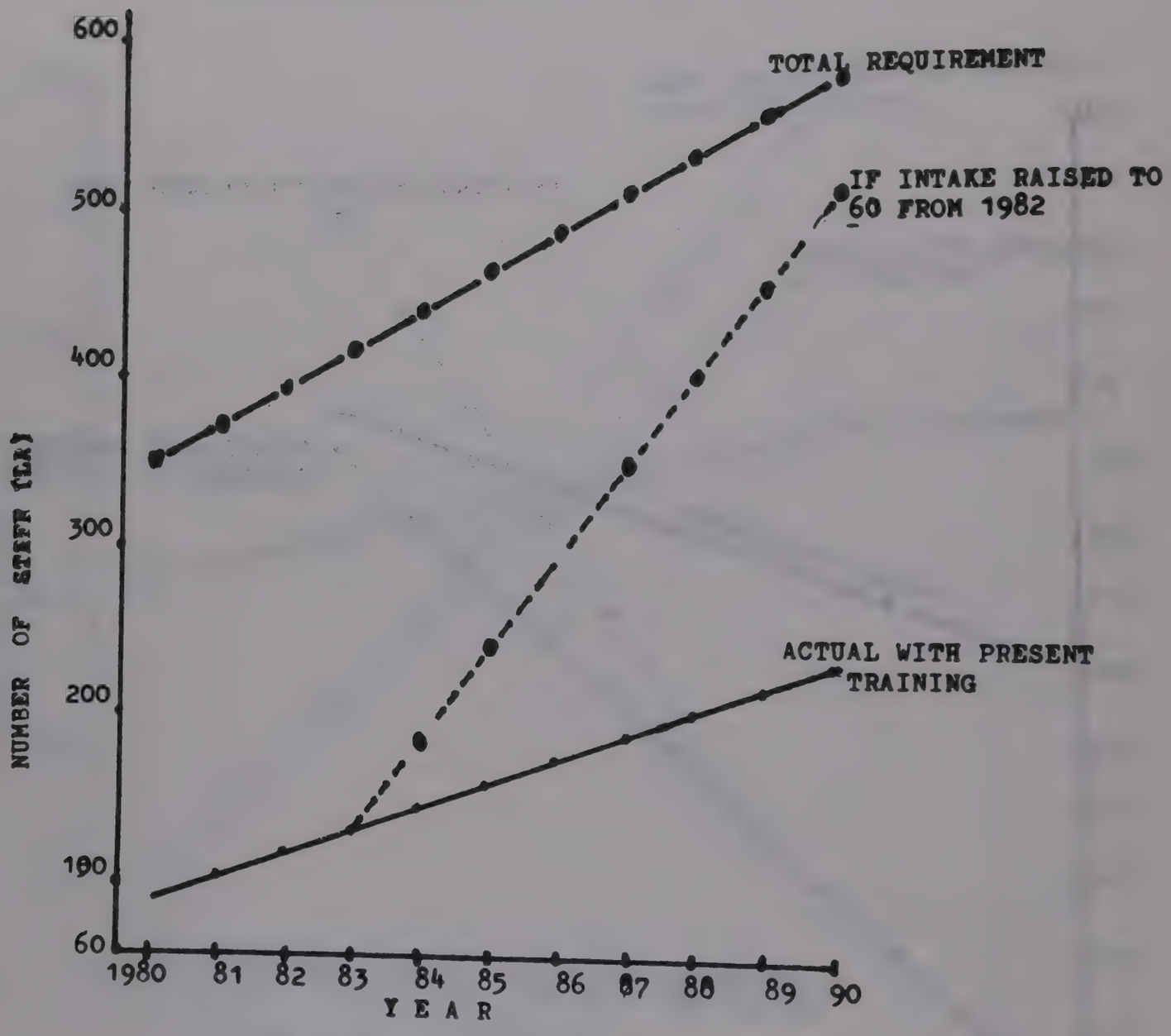
GRAPH 4 HEALTH INSPECTORS (HI)



RECOMMENDATION:-

INCREASE INTAKE BY 5 TO 20 FROM 1982

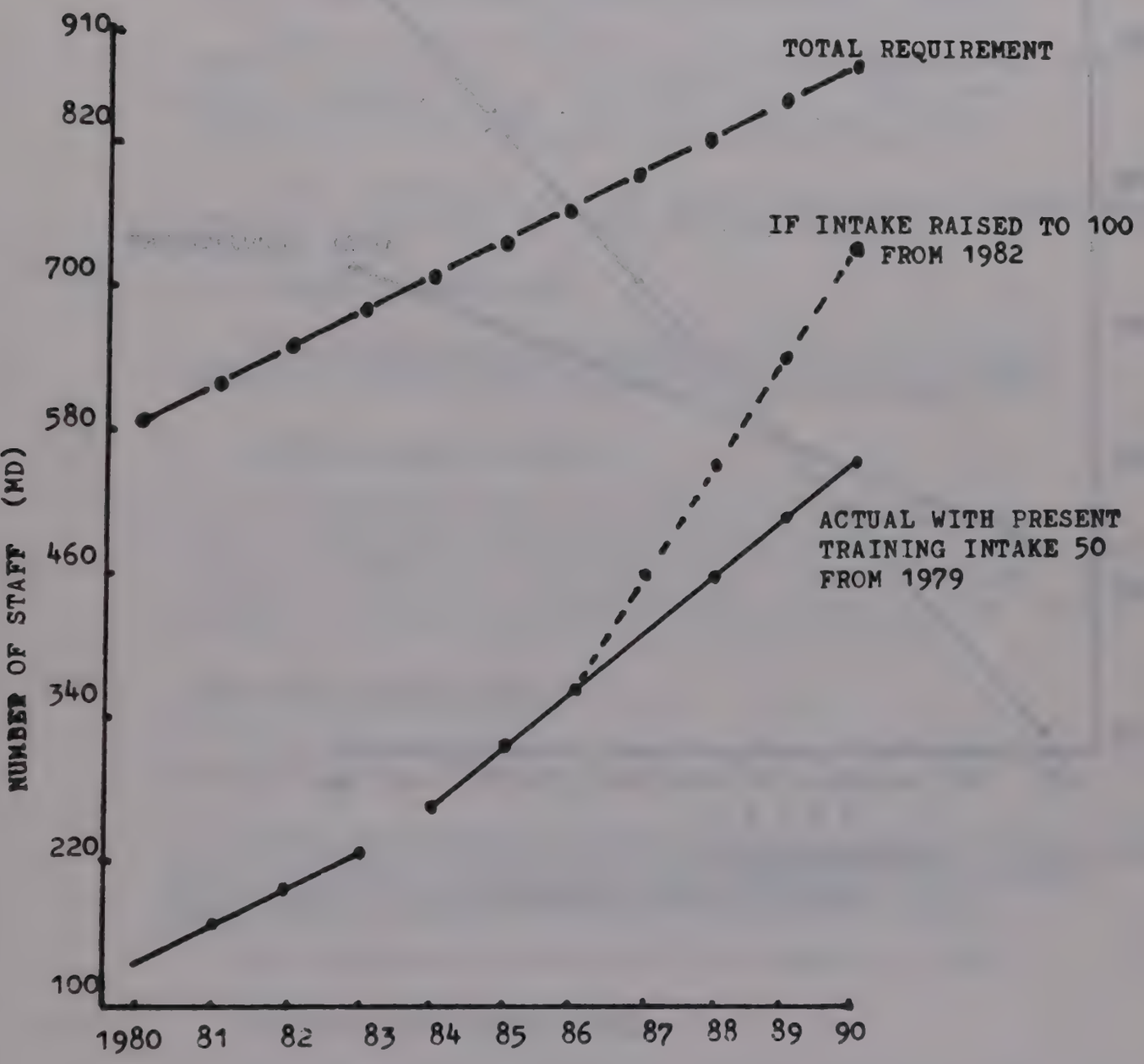
GRAPH 5 LABORATORY ASSISTANTS



RECOMMENDATION:-

INCREASE INTAKE BY 40 TO 60 FROM 1982

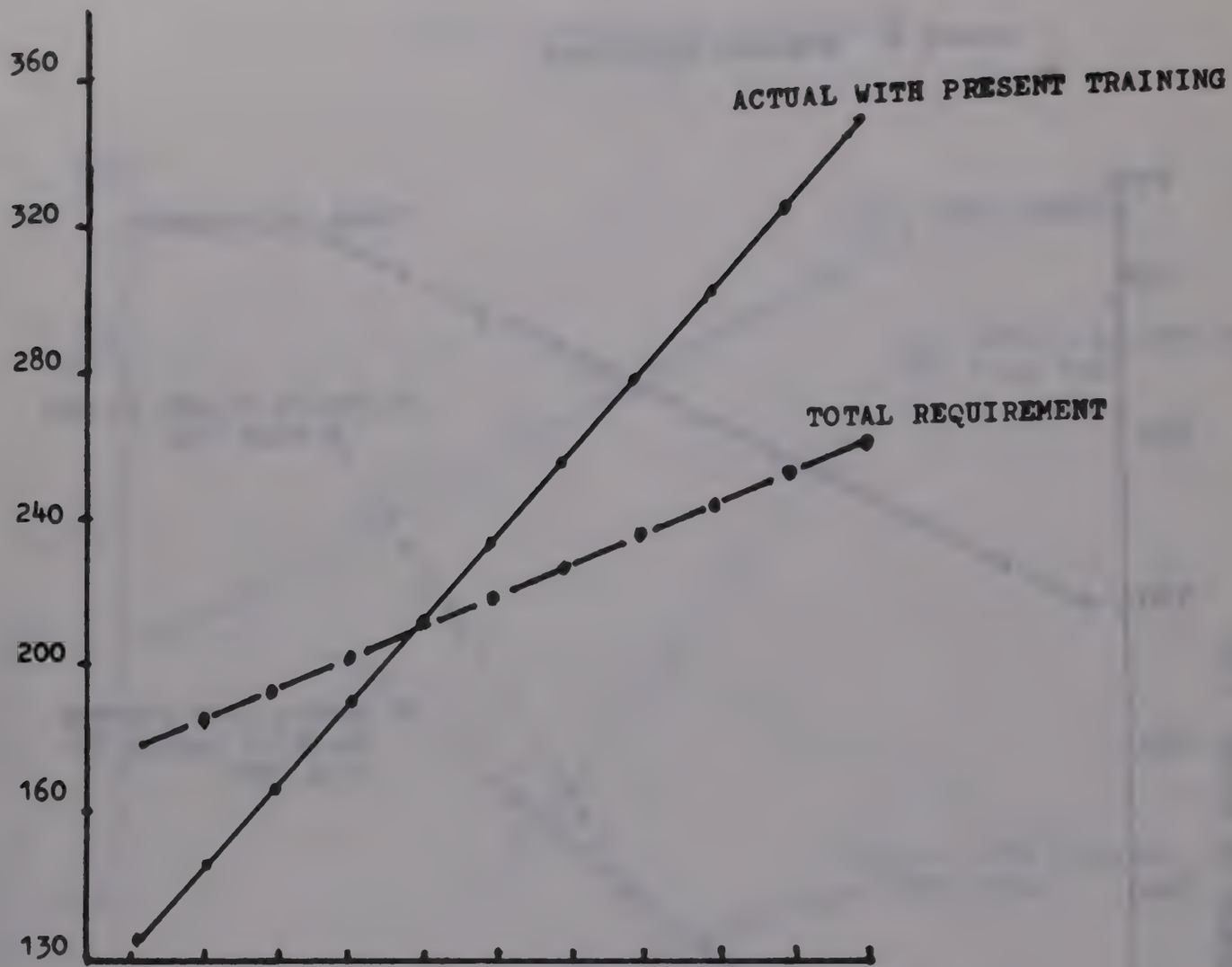
GRAPH 6 MEDICAL GRADUATES



RECOMMENDATION:-

INCREASE INTAKE TO 100 FROM 1982

GRAPH 7 PHARMACEUTICAL TECHNICIANS (PT)



RECOMMENDATION:-
PRESENT SCHOOL ADEQUATE

4.4 PHC Co-ordinators

This is a very important cadre for the PHC programme. Only 36 have been trained so far.

It is proposed that 20 should be trained annually in order to produce sufficient to staff each Health Zone as well as one each at Provincial level.

These will be drawn from Medical Assistants and Health Assistants. Furthermore, as they are predominantly field officers who much travel frequently male officer will be favoured.

Their training course which has halted temporarily must be restarted as soon as possible.

4.5 Health Inspectors

It is proposed to increase the annual intake from the present 15 up to 20 per year from 1982.

4.6 Public Health Nurse

At present these are needed in general hospitals and in the large District hospital teams. Later they will be needed in every District hospital team. The present output is adequate but if need be the intake can be increased according to requirements.

4.7 Laboratory Assistants

The present annual intake of the two existing schools is 18. This is totally inadequate.

It is proposed to open 3 new training schools, each with an annual intake of 12. The existing schools will each increase their annual intake to 12.

The proposals should be initiated in 1982.

4.8 Doctors and Specialist

Doctors are required to staff District hospitals. In addition each District hospital should have a public health specialist to function as the District Medical Officer. A Diploma in Public Health will be required for these posts.

In order to provide adequate medical staffing of all hospitals the following are proposed:-

(a) The intake of the Medical School should be doubled to 100 per year

(b) Training of specialists in Zambia should begin as soon as possible.

The remaining categories of staff are not dealt with in this document. However the Planning Unit of the Ministry of Health will develop an overall manpower development plan ensuring that PHC development has priority and that undue concentration of personnel do not develop in urban hospitals.

5. FURTHER REQUIREMENTS TO FACILITATE DEVELOPMENT OF PHC

5.1 Staff Housing

Adequate accommodation will be provided for health workers as a matter of highest priority.

5.2 Career structure

Satisfactory career structures must be established for all cadres. This should include clear policy on service in rural areas.

5.3 Training

In all courses present training is hospital based and patient oriented. Community health has low priority. If PHC is to succeed all health staff have to understand it and accept it and to know exactly where and how they fit into the system.

5.4 Refresher courses

Opportunities for staff to attend refresher courses will be provided. These are essential if proper standards of work are to be maintained. They must include multidisciplinary seminars and workshops.

5.5 Orientation courses for expatriate personnel

All expatriate personnel will undergo orientation training in PHC and community health for the same reasons as in 5.3 above.

Chapter 2.6 HEALTH CENTRE DEVELOPMENT

6. HEALTH CENTRE DEVELOPMENT

1. BACKGROUND AND EXISTING SITUATION

1.1 The health centre network and its functions in PHC

The health centre network, being the very backbone of the national health system, forms the contact point between the PHC workers and the health care system whether in urban or rural areas..

Apart from its basic obligations in delivering health services the health centre function with regard to PHC is to:-

i. promote and monitor the activities of Community Health Workers (CHW) and to carry out enviromental sanitation, MCH and health education programmes within its area of responsibility..

ii. receive and treat patients who are referred from the CHW and if need be to send them to a higher level in the health system.

iii. keep supplies of drugs and equipment needed by the CHW (Distribution is dealt with in Chapter 2.8)

The minimum staff at this level is one Medical Assistant (MA), one Health Assistant (HA) and one Enrolled Nurse/Midwife (ZEN/ZEM)

N.B. In urban areas the HA may be employed by the local authorities and stationed elsewhere than at a clinic.

1.2 Present coverage from health centres

In urban areas all but two towns with more than 5000 inhabitants according to 1974 sample census have got urban health centres (or departmental ones in three towns). This means that the geographical coverage of the urban population is acceptable. However, capacities of the health centres, their relations to hospital OPDs and their siting in relation to population centres must be considered from case to case.

In rural areas the geographical covereage varies from province to province and between districts. Present coverage is expressed as a proportion i.e. the rural population within 12 km radius as the crow flies (15-20 km in reality) to the total rural population.
(see TABLE on following page)

TABLE

HEALTH CENTRE COVERAGE OF RURAL POPULATION BY PROVINCE

	CP+LUS	CBP	EP	LP	NP	NWP	SP	W
Coverage	59%	83%	84%	78%	52%	65%	75%	5
Uncovered rural population	177.000	15.000	92.000	75.000	280.000	97.000	119.000	238

The Population per RHC is on the average 7.100 with variations from 3.000 in Ndola Rural to 21.500 in Mporokoso District.

2. OBJECTIVES

The long term and overall objective is to provide PHC in inhabited areas. This may be done with a RHC as a base which together with its catchment area will constitute a PHCU. However there will be areas where it will not be possible to base the PHC activities around a RHC, specifically areas where population is very scattered and population density is low. The objective of the expanded services as it relates to RHC development will therefore be:

i. to construct RHCs in all areas which meet the basic criteria

ii. to create alternative solutions in remaining areas i.e. beyond the RHC catchment areas.

3. EXTENDING THE OVERALL COVERAGE

3.1 Setting criteria

The catchment area of an urban clinic is related to the immediate surrounding population served whereas in rural areas it is defined by the geographical area which a health centre staff can visit regularly - usually bicycle distance. The catchment area must be mapped out and will constitute a health centre's area of responsibility

A distance 12-15km is acceptable as reasonable bicycle distance and will determine the catchment area in rural setting However this criterion should be relaxed where local physical conditions so demand e.g. presence of rivers, hills and sand preventing the use of bicycles.

A population of 2500 is the absolute minimum number that can justify an efficient utilization of the basic team of 3 qualified staff and the construction of a health centre in rural areas.

Following studies on the workload generated by a community and its consequences on the required numbers of health workers and a proposed organizational structure there will be three types of health centre in the rural ares:

i. The small rural health centre, HC/I (now known as stage I or health sub-centre). This unit will serve a population of between 2.500 and 5.000. The staff will be a minimum of 3 (see Chapter 2.5) and the number of beds 6 to 12..Its obligations are confined to the catchment area. (12-15 km radius)

ii. The large rural health centre, HC/II (now known as stage II) This unit will serve a population of between 5.000 and 10.000. The staff will be a minimum of 5 (see Chapter 2.5) and the number of beds 15-20. Its obligations are confined to the catchment area (12-15)km.

iii. The Zonal Health centre, ZHC. This will be a large health centre like (ii), which will serve the whole of the health zone (see Chapter 2.1). The minimum staff required is 11 (see Chapter 2.5).

When the population in a health zone reaches 30 - 50.000 a small hospital is required, possibly an upgraded ZHC. A further elaboration on the hospital functions is outside the scope of this document.

Urban health centres will vary in size and staffing in accordance with the number of people they serve. Before setting criteria further studies must be conducted.

A number of constraints limit the number of health centres that can be established. When setting a realistic target consideration must be given to available staff and planned output from training schools, that accommodation, transport capacity for maintaining services and financial resources for capital investments and recurrent expenditure.

3.2 Additional health centres

In order to support PHC in rural areas the health centre network must be extended. Given the criteria of 12 km radius and a minimum number of 2500 population within the catchment area an additional 200 new small rural health centres will be built and distributed with only a few in the best served districts and the largest number in the poorest served districts.

The extended network is estimated to cover 80% of the rural population. The figure of 200 additional RHCs over an 8 year period is reasonable in view of the constraints mentioned earlier but it must be emphasised that the location of RHCs and subsequent deployment of staff must then follow the criteria of 12 km radius which means a minimum distance between two RHCs of about 25 km as the crow flies. It should also be noted that existing health centres must be maintained and improved to meet basic requirements. An estimated 200 - 300 RHCS will need substantial improvements.

NOTE: It may serve as a reminder that if the radius is set at 8 km (16 km between two RHCs) the additional need in the country would be almost 1000 new RHCs.

3.3 Remaining areas

The health centre network can never cover the entire population. Firstly there are areas where the population is so scattered that coverage is not possible. Secondly before the network is extended as envisaged above those areas where RHCs have not yet been built will be beyond reach from any existing health centre. Consequently the uncovered areas will have to depend on other solutions for their support of PHC activities. The basic solution is the creation of Health Zones as discussed in Chapter 2.1. This means that the responsibility will rest with the zonal health centre or the district hospital where adequate transport for mobile teams must be provided. Other solutions may be:-

i. Extension of mobility and areas of responsibility at suitable health centres e.g. through provision of motorcycles (health staff).

ii. Utilisation of public transportation such as bus services (CHW and health staff).

iii. Utilisation of local transport from the community (CHW).

iv. Utilisation of transport through intersectoral co-operation (health staff).

v. Improvement of roads

vi. CHW to use whichever indigenous mode of travel to the health centre that is practicable.

3.4 Implementation

Implementation of the building programme must be preceded by detailed planning. The need for about 200 RHCs as indicated above is based on material information at central level. The actual siting and coordination with developments in other sectors must be done at Provincial

level. The planning for TNDP is a base to start from but it will be carried further to a long term RHC development plan. On-going self help projects are particularly important and a policy on how to deal with such projects will be formulated.. Also staff accommodation is a major problem in that the present number of houses available is far from sufficient and the gap between houses needed and those built is increasing every year (see also Chapter 2.3)

There are then two major activities required to implement the building programme i.e. planning and construction (apart from financing which is dealt with separately).

4.1 Planning

At District and Provincial levels this will include
- inventory of existing staff houses
- inventory of on-going self help projects
- establishing RHC areas of responsibility (catchment areas)
- establishing health zones and designating zonal health centres
- establishing a health centre master plan (long term)
- elaborate requirements for a housing programme
- a similar planning procedure should take place in urban areas under the responsibility of City Councils. It should also result in a health centre master plan.

At Central level it will include
- issuing quidelines for self help projects (on-going and new)
- compiling and coordinating Health Centre mast plans, proposals for health zones and housing programmes
- developing appropriate designs and technology including the dissemination of information on these subjects.
- exploring and following up means of expanding community participation in building activities.

4.2 Construction

The construction of RHCs can be undertaken:-

i; by contractors or PWD

ii. departmentally by PMOs building teams incorporating community participation

iii. on a self help basis.

iv. by industrial and agricultural employers.

The choice of method will have a bearing on cost, technical standard add time for completion of the projects. It must be emphasised that PHC, based on community participation, implies by definition a method whereby the Government and the community cooperate.. Since a building is a very permanent thing it may well serve as a lever to initiate PHC activities provided a concerted effort is put in by both Health Authorities and the community.

3.5 Self help and community participation

The majority of health centres will be constructed, improved or maintained on a community participation or self help basis. There is a clear evidence that people are prepared to cooperate in such a way and this potential will be engaged in an organized way. Secondly the task of expanding and maintaining the health centres is of such a magnitude that unless the community is sharing the burden the goal of health for all will not be attainable.

The input by the Government will be:-

- provision of building materials which cannot be provided by the community. Examples of these are roofing sheets, cement, doors and windows, paint etc.

- technical advice and support from a departmental building team.

- equipment

The input by the community will be:

-
- labour
- locally available materials like sand, stone for concrete, burnt bricks etc.
- construction of shelters for the relatives of inpatients
- possible cash constributions

The prerequisite for embarking on a self help project is an active, motivated and organised community with a well established Section or health committee. However it is equally essential that self help projects are in line with the overall plans of the Ministry of Health so that resources, particularly manpower, can be deployed according to need throughout the country as a whole.

In addition self help projects must follow a proper procedure of approval by the District and provincial Councils which will involve the technical advice and opinions of the PMO and his building team.

When it has been agreed that a self help project is necessary construction may proceed. The following will serve as an example for procedure.

Before embarking on a self help venture there must be an active section or health committee and a CHW. There must be a genuine community desire to undertake the project, a joint decision with the PMO and approval by the District and Provincial Councils. When this has been achieved the following can serve as an example of how a joint effort can be organised:

i. The community constructs a staff house for the HA

ii. a HA is posted and helps in organising the PHC activities and further construction work. He can also start his preventive work and should support the PHC activities

iii. the MA's house is constructed, an MA is posted and he will continue to support the PHC activities and further building works

iv. the RHC including all its amenities is completed This includes staff housing, protected water supply, pit latrines etc.

v. the equipment is provided

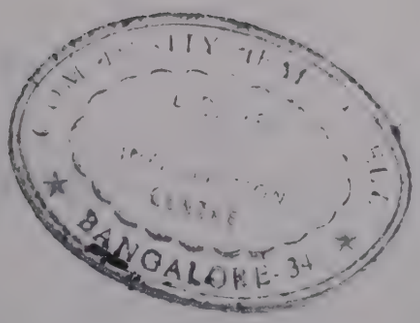
The PMO s building team will play a very important role in guiding and assisting community participation in the construction and maintenance of health facilities.

Further details on planning and carrying out self help projects will be provided in a Ministry of Health policy document to be published early in 1981 (see also Chapter 2.2)

3.6 RHC Construction by industrial and agricultural employers

Organisations such as large farm schemes, tobacco and sugar producers etc should be encouraged to establish their own clinics. However the planning, construction and functioning of the clinics should be carried out in consultation with PMO.

To be properly effective the clinics should serve the local community and not be restricted to employees.



Chapter 2.7 TRANSPORT

7. TRANSPORT

1. BACKGROUND

A well functioning transport system is an absolute prerequisite for the delivery of health services. It must facilitate the following functions:

- travel by health staff to perform duties in the communities i.e. outside the health centres and hospitals
- supervision of health work and promotion of improved performance at various health units
- delivery of medicines and other supplies
- maintenance of equipment and buildings (where this is not done by PWD)
- referral of patients and ambulance services

With regard to PHC mainly the first three functions are relevant and this Chapter will deal only with these. It must be noted however, that the transport system serves the nation's health service as a whole which means that consideration must be given to all aspects when planning for improvements.

Although the provincial level is important in the overall transport system it is not included in this document.

1.1 Modes of transport

The modes of transport can be summarised as departmental, public transport and other means of transport.

i. Departmental transport in use today includes:
- bicycles used mainly at RHC level
- four wheel vehicles (GRZ and Specialist) at District, Provincial and Central level. This includes passenger cars, 4 wheel drive vehicles, ambulances and a few trucks
- motorcycles in a limited number mainly used in the National Immunisation Campaign
- boats in a limited number used on the lakes and swamps in Northern and Luapula Provinces, on the Zambezi and Kafue rivers and in the Lukanga Swamp.

ii. Public transport is primarily available as:

- bus services operated either by UBZ or private companies.
- the railways operated by Zambia Railways and Tazara.
- commercial air line service used for distribution of vaccines (in order to maintain the cold chain).

The public transportation systems are not much used in health services but the bus services and railways offer a useful potential.

iii. Other means of transport include the ways and means usually employed by people in travelling from place to place. These may involve company or parastatal transport, private vehicles, hitch-hiking etc.

Since these methods are so widely used they offer important possibilities within the PHC system e.g. for delivering supplies to the CHW or the RHC and for transferring patients.

1.2 Present transport situation

(see TABLE 16)

It should be noted that only 21% of the number of available vehicles are roadworthy. As for bicycles it is reported that where they exist most of them have broken down and the ones in working condition are negligible in number. This also applies for the few boats available.

1.3 Constraints

The constraints facing the transport system are well known and in order to combat the difficulties the following problem areas have to be considered:

- poor quality of bicyles
- poor maintenance and repair of vehicles and bicyles
- large variety of makes of vehicles
- irrational use and misuse
- increasingly high fuel costs
- unrealistic write off time leading to low rate of replacement
- reluctance by health staff to use public transport and poor reimbursement arrangements if public transport is used.

TABLE 16

FOUR WHEEL VEHICLES AS AT 1ST DECEMBER 1980

	No. of vehicles	No. of vehicles in running condition	No of repairable vehicles	No. of vehicles beyond economic repair
Ministry of Health HQ	40	13	22	5
University Teaching Hospital	55	10	37	8
Chainama Hills Hospital	11	3	7	1
Central Province	47	11	33	3
Cpperbelt Province	72	16	48	8
Northern Province	71	19	38	14
Southern Province	65	16	41	8
Eastern Province	61	12	44	5
Western Province	58	8	42	8
North-Western Province	51	8	37	6
Luapula Province	45	7	31	7
	576	123	380	73

2. OBJECTIVES

The overall objective is to create a functional back up system for PHC activities primarily in villages in rural areas. This can be done by:-

i. promotion and support of PHC activities in villages within the PHCU by the PHC staff

ii. ditto within the outlying areas by the health zone staff (stationed at zonal health centre)

iii. organising, supervising, training and evaluation by the PHC Coordinator

iv. delivery of medicines and other supplies

Effective means of transport are essential.

It should be noted that provision of transport referral c patients will not form part of the PHC system. It must also be stressed that health transport in rural areas should be regarded as a multipurpose transport which means that staff, supplies and, if necessary, patients will use the same vehicle

3. TRANSPORT FOR PHC

3.1 Essential transport at various levels

3.1.1 Village level

The CHW must maintain regular contact with the RHC and collect drugs and supplies.

It is the intention of the Ministry of Health to provide each CHW with a bicycle. However maintenance and repair of the bicycle will be the responsibility of the community.

3.1.2 RHC level

The RHC staff will move about in the catchment area supervising and organising PHC activities as well as performing their ordinary medical duties in the villages.

To fulfill these obligations bicycles will be allocated individually to the MA, the HA and ZEN/ZEM. This means 3 bicycles at the smallest RHCs.

The RHC staff also have to arrange supplies of medicines and other supplies when the monthly allocation from the district level runs out. There will also be a need for contact with higher levels e.g. in administrative matters.

To meet these requirements public transport should be used (and paid for) where it exists. Other means of travel used by the local people on errands to the boma should also be utilised by the RHC staff. In short it means that non-availability of transport or non-delivery of supplies from the district will not be a valid excuse. If there is a shortage the RHC staff must have the initiative to correct the situation using whatever mode of transport that is practicable.

3.1.3 Health zone level

The zonal health centre functions as a RHC in its area of responsiblity, thus 3 bicycles will be required (as in 3.1.2). The staff must organise PHC activities in outlying areas (beyond and between catchment areas of RHCs) at a distance of up to about 50 km.

To do this efficiently a 4 wheel drive vehicle is required. Such a vehicle could carry 2 or 3 team at a time.

The PHC Coordinator stationed at this centre will be organising, supervising, training and evaluating PHC activities. The appropriate transport is a motorcycle (125cc).

3.1.4 District level

The district hospital functions as zonal health centre in its health zone and thus will need 3 bicycles, one motorcycle and one 4 wheel drive vehicle.

The District hospital also performs secondary health care, distributes supplies to the RHCs on a monthly basis in conjuction with routine visits by the Medical Officer and carries overall responsibility for health care within the district. This indicates a need for at least one other vehicle. There will then be a minimum of two 4 wheel vehicles at district level of which one should be suitable to carry patients (ambulance type).

NOTE: Further assessment of the transport requirements for the secondary health care system is beyond the scope of this chapter.

3.2 Implementation

In order to create a functional transport system to run and back up the PHC system consideration has to be given both to the specific demand related to PHC and to the transport system as a whole.

3.2.1 Transport related to P.H.C

Action required by the Ministry of Health will include the following:-

i. The provision of four wheel vehicles, motorcycles boats and bicycles from central level. This will entail purchase, allocation and budgetary planning for replacements based on realistic write-off periods. The provision of vehicles will be phased to the gradual development of PHC.

ii. The establishment of provincial workshops to maintain and repair Ministry of Health vehicles motorcycles and bicycles.

iii. The creation of funds for urgent local repair of vehicles when necessary.

iv. The creation of stocks of bicycles spare parts at District level.

v Rationalisation of transport routines at Health zone and District levels including control of use.

vi. Establishment of training in maintenance of 4 wheel vehicles, motorcycles and bicycles and repair of bicycles.

vii. Establishment of procedures at District level for reimbursement of fares when public transport is used b health staff on duty.

viii. Promotion of the use of public transport by healhh staff as a means of fulfilling their duties.

3.2.2 Overall health transport system

As already mentioned transport for PHC is just one part of the whole transport system for health. Thus efforts to develop an effective system for PHC require the problems of the whole transport system to be tackled. In particular careful consideration will be given to the following:-

i. C

i. Control of vehicles. All vehicles engaged in PHC work at provincial level will be controlled by the PMO. At district level the DMO will have overall control

ii. Standardisation of vehicles and bicycles. In view of the high cost of petrol a change to diesel powered vehicles may be indicated.

iii. The appointment of Transport officers in every province to rationalize the use of vehicles as well as maintenance and repair. He will be an experienced mechanic.

iv. The creation of a replacement policy for each type of vehicle i.e. to decide when vehicles have reached the end of their useful lives and require replacement.

v. Effective planning for budget estimates.

Solutions to the transport problems require expertise and considerable effort. As a first step an experienced transport planner has been recruited to undertake a detailed examination of the present situation and identify the actions necessary to bring about a rapid improvement in the transport system.

Chapter 2.8 DISTRIBUTION OF DRUGS AND SUPPLIES

8. DISTRIBUTION OF DRUGS AND SUPPLIES

BACKGROUND AND EXISTING SITUATION

Distribution of drugs as it relates to PHC is one part of the general drug distribution system. The additional services introduced by PHC require a limited supply of drugs for the CHW. In order to provide this additional supply effectively the whole distribution system must be examined.

Distribution is taken to include all procedures from making the requisition until final delivery of the drug.

1 Requisition

Requisitions are made at District level, passed to the PMO and then passed on to Medical Stores Ltd., (M.S.) in Lusaka. Exceptions are requisitions for instruments and equipment which come out of a Headquarters vote and special drugs in part B of certain sections which require Headquarters approval. Such requisitions will be passed from PMO to Ministry Headquarters and then forwarded to M.S.

The postal service is used resulting in a considerable time lag from the time of making the requisition until it reaches M.S. In addition processing at the PMO's office is often time consuming. It is therefore a matter of many weeks before a requisition reaches M.S. for action.

It may also happen that M.S. is short of the drug requested and by the time the health unit in the District has been informed it may be a matter of months after the request has been made.

2 Distribution

Distrubution of drugs is carried out by M.S. by truck to all hospitals and a limited number of RHCs. Most of the vehicles are on the road and repairs are done in private garages. M.S. also has a connection to the railway line but this is not utilised in distributing drugs. Distrubution follows a number of fixed routes, roughly 2 per province and when a full truck load has been gathered for a particular route the consignment is despatched.

A route is usually operated once and at times twice a month though e.g. Copperbelt may receive weekly supplies.

The resistribution of drugs from District hospitals to RHCs is done by Ministry of Health.

Vaccines which have to be maintained at low temperatures during storage and transport are sent by air (Zambia Airways) to places designated by the Provincial Medical Officers and where regular air service is maintained. Such despatches are made every 3 to 4 months.

1.3 Constraints

The major constraints in distrubution are:-

- slow requisition
- weak organisation at PMOs offices
- insufficient transport capacity especially for the redistribution from hospitals to RHCs.
- inadequate storage space at hospital and lack of staff accommodation for dispensing personnel
- thefts

The weakest links in the chain appear to be the requisition process and redistribution.

2. OBJECTIVES

The overall objective is to ensure that CHWs get a regular supply of the drugs and other equipment necessary for his job. This implies that adequate supplies must be distributed to and maintained at:

i. RHCs
ii. Zonal HCs
iii. Hospitals

They must act as depots from which the CHW can obtain his supplies are required.

Reliable distribution of vaccines is also essential for PHC since immunization forms an important part of PHC activities. Thus a reliable cold chain must be established.

3. IMPROVEMENT AND EXTENSION OF THE DISTRIBUTION SYSTEM

Distribution will rely on the existing system where M.S. distributes from Lusaka to all hospitals and, where roads permit, to health centres. The basic reasc is that the system has developed over a long period of time and has previously worked well. However, improvements are necessary. There will then be the following componentss-

- improvements to the existing system
- procedures for supplying CHWs

3.1 Improvements will be made on the following:-

1. Requisition procedure

First there is need for planning ahead and taking due account of the time lag involved in the process. Provision exists in the M.S. system for requisitions of individual items to be held for future supply when stocks become available (see paragraph 4 of M.S. catalogue notes). This should be more fully utilised.

In addition all requisitioning officers must be made fully aware of the ordering procefure

Secondly, a telex system should be installed at PMOs headquarters, Ministry Headquarters and M.S. to be used for urgently required items and for balancing supplies between provinces (one PMO may have surplus where others have run short; drugs about to expire can be redirected). Also M.S. can keep all PMOs up to date on availability of drugs through regular telex messages on the stock situation.

NOTE: Telex is a widely used means of communication where written information is necessary. It is commonly used in private enterprise for ordering supplies etc.

All provinces, except Western Province can have can have telex connected to the telecommunications system.

ii. Handling at PMOs office

There must be adequate technical personnel to handle requisitions, control of drugs and redistribution. A Pharmacist/Pharmacist technician will be posted at each PMO's office to assume these responsibilities. This officer will also act as Poisons inspector. Staff accommodation must be provided.

iii. Buffer stocks of drugs

A regional store will be set up at Provincial Headquarters with facilities to keep a limited range of important items for distribution to hospitals and health centres when their regular supplies from M.S. have not arrived. A proper record system will be instituted from a medical unit through to Ministry of Health Headquarters in order to have proper information.

iv. M.S. distribution system

This can be improvedby making use of the railways. The establishment of decentralized M.S. depots at Kasama and Choma will be explored. Vehicles would then be stationed at these depots which would receive supplies by means of sealed railway wagons. This would enable the trucks to spend more time on effective distribution routes and would also result in a saving on fuel.

v. Redistribution from hospital and zonal health centres

A regular and suffitient supply of drugs must be ensured from District Hospitals to RHCs. The following are planned as means of improving redistribution:-

- an increase in the number of vehicles
- delivery of a predetermined basic supply when health centres are visited for purpose of supervision e.g. monthly. The basic supply must be in accordance with the National Formularly Committee list.
- use of public transport. This may be done by sending a member of the health centre staff with a locked drug box to collect supplementary supplies.
- the RHC staff should be responsible for collecting all supplementary drugs from the hospital or zonal health centre.

vi Improvement of storage facilities at hospitals, zonal health centres and RHCs

The pharmacist/pharmacist technician, mentioned above, will assess the total stocks needed at each hospital and zonal health centres in order to ensure adequate, regular supplies to health centres. Extra storage facilities may need to be built.

In addition there must be a universal and unified system of recording stocks. A card and ledger system will be used. Proper rotation of stock is imperative.

vii. Improvements in the cold chain

New strategies have been adopted and are being tested in cooperation with UNICEF. Any new proposals must await an evaluation of this trial system which involves the use of cool boxes by trained staff.

3.2 Procedures for supplying Community Health Workers

The CHW will collect drugs on a monthly basis at the RHC (when the village is within a PHCU) or at the zonal health centre/hospital.

It is not yet possible to predict the pattern of consumption of the simple medicines supplied to the CHW. Part of the supervisory role of health centre staff will be to help the CHW assess his medicine requirements and prevent wasteful and costly dispensing.

3.3 Items to be supplied to the CHW

The following are the items to be used by CHWs. These will be stored in a secure place provided by each community.

Antiseptic
Benzyl Benzoate emulsion
Gential violet paint
Cough linctus
Chloroquine tablets and syrup
Paracetamol tablets/soluble aspirin
Ferrous sulphate/Folic acid tablets
Pyrantel pamoate tablets
Sulphacetamide eye ointment
Vitamin A capsules /Cod liver oil
Multivitamin tablets
Oral rehydration electrolyte packets
Dressings and bandages
Scissors
Thermometer
Arm circumference tape (locally made)
Pulse glass
Zinc Oxide plaster
Disifectant
Insecticide
Measuring and dispensing spoons
Water purifier

During training instruction will be given in making items such as splints, disposable tongue depressors et.

NOTE: This list does not include items required by the Traditional Birth Attendant.

4. PROCUREMENT OF DRUGS FROM ABROAD

Attention must be drawn to the considerable problems involved in procuring drug supplies from abroad. Such supplies comprise the bulk of the drug requirement for the whole national health system.

Under the present system orders placed under the full tender procedure will not be received in Zambia for at least 12 months, even when delivered by air. For orders not requiring a full tender procedure it will take at least 8 months to receive the goods. This is not acceptable even allowing for frequent unavoidable difficulties in obtaining foreign exchange allocations.

The major causes of delay at present revolve around the preparation and processing of Letters of Credit to the suppli A letter of Credit is a legal document and must be absolutely correct in every detail. Frequently amendments are necessary before an order of drugs can be finalised. Unfortunately errors may slip through at this stage and may not be detected until much later resulting in even further delay until proper corrections have been made.

Apart from drug shortages in Zambia another result of delay is a surcharge on the goods due to inflation during the delay period.

The introduction of an effective procurement procedure is urgently required. One possibility is to arrange for orders to be processed by a Confirming House abroad e.g. NIECOS, London, who would arrange not only the processing of orders but also payments to suppliers on a cash against documents basis.

Where a local agent is successful in securing a tender, foreign exchange should be made available so that they can import without undue delay.

A task force will be established to recommend ways of developing an effective process for procurement of drugs from abroad. The task force should include representatives of the Ministry of Health, Medical Stores, Ministry of Finance and NIECOS.

5. LOCAL MANUFACTURE OF DRUGS

The local manufacture of drugs must be encouraged. To this end a feasibility study of local manufacturing capacity and potential has been conducted by a team of experts from UNIDO, the results to be followed up by the Ministry of Health.

6. TESTING OF DRUGS

There is an urgent need to establish facilities at the Food and Drugs Laboratory for testing of drugs to ensure they meet accepted standards in line with provisions of the Food and Drug Act.

However there is first a need for the completion of legislation concerning the legal infrastructure in the control of drugs to allow for examination for safety and effectiveness.

Chapter 2.9 STRATEGIES FOR INCREASED CO-OPERATION BETWEEN TRADITIONAL AND GOVERNMENT HEALTH SERVICES

9. STRATEGIES FOR INCREASED CO-OPERATION BETWEEN TRADITIONAL AND GOVERNMENT HEALTH SERVICES

INTRODUCTION

It is essential for the promotion of PHC in Zambia that greater cooperation should be generated than presently exists between the Government Health Services and traditional health services.

Categories of 'traditional health practitioner' in Zambia and their nosological (disease classification) systems

The several categories of people recognised as healers by rural Zambian communities include:

1. Specialists in the divination of sources of distress within the community or witch-seekers in the field of spirit possession. (spiritualists),

2. The herbalist whose approach to treatment often appears relatively closely akin to the nosology of cosmopolitan medicine.

3. Another category of traditional specialists focuses on a number of life crises, some of which are of concern to cosmopolitan medicine. In Bemba custom the Nacimbusa has a special role to play as mistress of ceremonies at girls' puberty rites (Chisungu), in child birth as the midwife, and as a god-mother to the young child. In Luvale custom, the Chipungu is the specialist who performs the operation of circumcision at the boy's puberty rites (Mukanda) with the assistance of muka-funda. Throughout rural Zambia traditional specialists in obstetrics are to be found and their range of activities often extends into the fields of sex education and contraceptive counselling.

4. Another type of healing activity of considerable importance is faith healing. Some of the practitioners of this technique are representatives of major world religious movements. More common however, are the healers who represent local syncretic religious movements, such as the African independent churches.

The range of medical practitioners in Zambia operating outside the framework of the national health service is extremely diverse. It includes rural and urban men and women with many different local desinations whose precise connotations are difficult to capture with English translations. Some of these practitioners specialize in the treatment of certain conditions while others operate over a very wide range. Some regard their practices as a full-time occupation, while others consider it as of their normal social responsibilities. The theories which guide their various forms of treatment incorporate some features entirely consistent with cosmopolitan medical theory and others directly opposed to it.

2. THE PRACTICE OF TRADITIONAL MEDICINE

The service offered by traditional health practitioners differ from the national health service in two major respects: it is more firmly embedded in the social environment of the patient and it is more personalised.

2.1 A socially embedded health service

Patients of traditional practitioners are normally referred to them by a member of their kin-group. In rural areas the traditional practitioners are typically a member of the same ethnic group if not the same residential community as the patient. They are expected to and normally do speak to the patient and his or her escorts in their family language unlike the cosmopolitan doctor. Moreover, consultation and treatment sessions with traditional healers are often conducted in the patient's home.

The diagnosis or divination of the cause of a patient's illness by traditional healers tends to emphaise social rather than physical aspects of aetiology.

Treatment by traditional practitioners also tends to be embedded in the patient's social milieu. Ritual aspects of the treatment often require the active participation of several relations and may be witnessed by quite a large portion of the community. In addition the patient is often instructed to make specific short and long term changes in his social behaviour.

.2 Personalized treatment

Traditional practitioners by bringing their service to the home of the patient, by focusing their attention on the past, present and future social life of the patient and by their avoidance of bureaucratic and standardised procedures give the impression of tailoring their service to the needs of the individual patient.

2.3 Technology

For the most part indigenous health services make use of a small repertoire of home-made, low cost artefacts, although some of the urban practitioners have been known to make ecletic use of industrial products such as hypodermic needles and stethescopes. Some religious healers emphasise their rejection of all forms of drug therapy. However, the principle domain in which technology has been claimed by indigenous African medicine is that of pharmacology.

2.4 Clientele

There is a great dearth of information on the kinds of patients and afflictions which make up the case load of the various alternative health services. Comparison among various categories of illness across different types of health service agents would be extemely problematic even if adequate date were available. Patients are likely to present symptoms of their illness in terms they consider appropriate to the nosology of the practitioner they intend to consult.

.5 Payment

Little information is available on this topic. But it appears that most of the medical services are provided at a charge. Often payments are made in kind but sometimes considerable cash payments are made. Many traditional practitioners only accept payment on delivery of results. Religious healers and certain traditional midwives deny that they expect any payment for the services they provide.

3. PRESENT RELATIONS AMONG ALTERNATIVE HEALTH SERVICES IN ZAMBIA

This section looks exclusively at the relations between practitioners of cosmopolitan medicine and practitioners of traditional medicine.

3.1 Ignorance and mistrust

The lack of detailed knowledge referred to in sections 1 and 2 has its origins in the combination of disinterest and contempt with which cosmopolitan practitioners in Zambia have tended to regard the various alternative indigenous health services and the complementary attitude of independence held by most traditional health practitioners.

3.2 Theorectical inconsistency and practical incompatibility

The extent to which traditional and orthodox cosmopolitan practitioners' different approaches are in head-on collision or are capable of coordination and synthesis is a matter for careful assessment. Both types of practitioners see a lot of each other's cases. Conventional wisdom has it that they treat each other's failures.

An additional concern has been the eclectic use of modern industrial products by urban Ng'angas sometimes with harmful effects (Wober, 1976:214). On the other hand it is interesting to note that a substantial number of GRZ nurses and Health Assistants share certain non-cosmopolitan medical beliefs with traditional practitioners. (Edirisooriya, 1978). The possibility of subscribing simultaneously to cosmopolitan and traditional beliefs has been noted in other educated African groups (Jahoda, 1971) and seems to provide grounds for optimism for the prospect of integration.

3.3 Preliminary forms of cooperation

Although neither official policy nor professional traditions have been supportive hitherto of collaboration between the Government Health Service and traditional practitioners a number of individuals on both sides have inform sought to establish a loose form of communication and collaboration. For instance at the grass roots level Medical Assistants and traditional practitioners have informal contact with each other. The latter have occassionally referred some of their patients to health centres. A more formal type of collaboration between the Government Health Service and one category of traditional practitioner was innitiated in 1973 by the Ministry of Health through the training programme for Traditional Birth Attendants. There is a need to evaluate all aspects of this training programme.

4. ACHIEVEMENT OF INCREASING COOPERATION

4.1 Communication network

Efforts will be made to identify and strengthen communication already established between some traditional and cosmopolitan practitioners. Where it does not exist the Planning Unit through the Primary Health Care Coordinators will initiate the dialogue at the village level.

The most useful level of communication will be the community e.g. between health centre staff and local traditional health practitioners.

4.2 Association of traditional practitioners

The formation of an association of traditional practitioners will be encouraged. The Ministry of Health will only play a supportive role. The best approach to the traditional health practitioners should be through the traditional ruler via the District Secretary.

It is recommended that an association of traditional health practitioners should be formed at District level.

4.3 Identification of traditional health practitioners

The present system of registration of traditional health practitioners by the District Secretary must be strengthened.

A list of practising healers will be compiled starting from village level. This will eventually lead to the establishment of a national register giving the location and specialities of all traditional practitioners.

4.4 Shared learning activities studies on how traditional practitioners acquire their skills and areas of possible collaboration with cosmopolitan practitioners will be made. Seminars will be organised for both groups to share this information.

4.5 National-level coordination and monitoring

An advisory group composed of part-time professional people and traditional healers will be formed under the auspices of the Ministry of Health, supported by a full time secretariat for the explicit purpose of coordinating and monitoring activities described above. This body will also begin to lay groundwork for a national policy.

4.6 Training and public education

As a body of agreed knowledge and practice begins to emerge through such activities as those outlined above, these resources will be progessively introduced into training programmes mounted by Government for health staff. The community at large will also be kept informed of the growth of the movement. Intersectoral staff will be made aware of this community resource as it develops.

4.7 Research

Research into all aspects of traditional medicine in Zambia is necessary in order to build on the scanty existing knowledge.

A thorough and detailed research programme must be set upt to include:-

- identification and standardisation of medicines
- effectiveness of medicines
- social and psychological aspect of traditional practice

4.8 Legal implications

Studies must be undertaken to determine the legal implications of the actions recommended in this chapter.

5. CONCLUSION

A cautions approach will be adopted in planning for any future integration of traditional and cosmopolitan health services. Entrenched obstacles exist and will require to be broken down gradually.

Chapter 2.10 FOOD AND NUTRITION COMPONENT OF PRIMARY HEALTH CARE

1. INTRODUCTION

2. OBJECTIVES

3. ACHIEVEMENT OF BETTER NUTRITION

3.1 The Health Sector

3.2 Intersectoral Approach

10 FOOD AND NUTRITION COMPONENT OF PRIMARY HEALTH CARE

1. INTRODUCTION

Malnutrition as a major public health problem in Zambia is well documented. For example the prevalence of malnutrition ranges from 15% to 45% of the population in different communities; it is estimated to be directly or indirectly the cause of 70% of the deaths among children; an average of 24% of all primary school children examined by the schools medical services in Kitwe alone were found to be underweight in 1973.

The major population groups most affected are the children below 5 years and pregnant and nursing mothers. The causes of malnutrition are many and varied. Some of these factors include inadequate food supply, seasonal food shortages, poverty, ignorance, dietary habits, infections,,break up of marriages, decline in breast feeding in urban areas, and use of untrained nannies by working mothers.

Combating malnutrition therefore means tackling these complex and adverse factors simultaneously through an integrated and coordinated programme. The integration of nutrition in primary health care is one such useful approach for bringing nutrition activities to people at community level.

2. OBJECTIVES

Nutrition objectives in a multi-sectoral health programme include:-

2.1 Creating community awareness of the serious impact and consequences of the problems of malnutrition so as to stimulate local sensitivity and ability to work towards better nutrition/health in the community.

2.2 Assisting the community in the process of investigation by which they can identify nutrition/health problems so that they can plan appropriate activities to improve their nutrition and health status.

2.3 Educating and training the community in carrying out remedial measures in areas where the community has indentified particular problems.

2.4 Enhancing the collective capability of the local community to plan, implement and evaluate their health and nutrition projects.

3. ACHIEVEMENT OF BETTER NUTRITION

3.1 The Health Sector

3.1.1 The Ministry of Health in collaboration with the National Food and Nutrition Commission will establish a national nutrition surverillance system during 1981-1982. The system will be based on surveillance , at health centre and community levels, of the nutritional status of the under fives.

At the health centre level staff will record weight for age and height for age whilst CHWs will be trained in the use of tape to measure mid-arm circumference.

The aim of establishing the system is to enable problems to be identified and action to be taken at the local level i.e. within Districts and within the catchment areas of health centres.

The recording of data will take place at community and health centre levels as part of a new and less cumbersome health information system currently being developed by the Ministry of Health in order to improve the capabilities for planning and management at all levels from the periphery to the Ministry Headquarters.

3.1.2 Nutrition will feature prominently in the health education component of the PHC programme. For example, in the case of infant feeding stress will be placed on quantities of food to be given rather than quality which has formerly been featured.

3.2 Intersectoral Approach

Solution of the problem of malnutrition will require the efforts of many sectors. In the agriculture sector Operation Food Production is already under way while the efforts of the health sector have been described above.

For maximum effectiveness proper co-ordination is essential. To that end it is proposed that a task force drawn from senior officers of the Ministry of Agriculture and Water Development, the National Food and Nutrition Commission and the Ministry of Health be established to develop a joint programme of action to improve the nutritional status of the Zambian people. Emphasis will be placed on improving the nutrition of women and children from birth to 14 years.

Particular emphasis will be placed on the following:-

3.2.1 The training of field workers from these sectors in aspects of agriculture and nutrition.

3.2.2 The training of CHWs by workers from the agriculture sector (nutrition training is already part of their training curriculum).

3.2.3 Provision of simple agricultural implements and materials such as seed and fertiliser to facilitate community participation in food production and nutrition programmes. A considerable self help element should be encouraged in such programmes.

3.2.4 The initiation of joint reseach and development of appropriate technology to produce low cost implements and materials for use in food production and food storage

3.2.5 Expansion and improvement of training on nutrituon and food production in teacher training college.

3.2.6 Improvement of teaching on nutrition and food production schools.

Chapter 2.11 MENTAL HEALTH

1. BACKGROUND

2. STRUCTURE FOR MENTAL HEALTH SERVICES

2.1 Village level

2.2 Rural Health Centre

2.3 Urban clinic

2.4 Zonal Health Centre

2.5 District Hospital

11. MENTAL HEALTH

1. BACKGROUND

While mental health problems exist world-wide the citizens of countries, such as Zambia, in which rapid social changes are taking place, are especially vulnerable. This is particularly the case with respect to socio-economic development, changes of traditional cultural values (often with conflict), rapid urban migration and an extremely high proportion of women of child-bearing age and choldren in the population. Serious disruptions of family and community life occur in rural as well as urban populations.

A particular difficulty in preventing or coping with problems of mental ill-health is that illness often is the result of several causes acting in combination. Furthermore, it is frequently found that not only one family member but several are affected by such illnesses. In this connection it must be stressed that there is need for an appreciation of the mental health problem of women and children.

Zambia already has the beginnings of a mental health service and it now remains to bring its resources closer to all people in need while utilising the help of all who are capable of giving it. These range from the family, members of the community and particularly the Community Health Worker to professional health workers.

2. STRUCTURE FOR MENTAL HEALTH SERVICES

2.1 Village level

Training in mental health will be introduced into the curriculum of the CHW so that he can carry out the following tasks:-

- provide simple mental health education and information to encourage community co-operation in coping with mental health problems
- identify and refer people who may have mental health problems or epilepsy
- follow up people on treatment to ensure that medication is being properly taken and to encourage their acceptance within the community
- collection and maintenance of simple data about the mentally ill.

2.2 Rural Health Centre

The same team of health personnel i.e. general medical Assistant and enrolled nurse will be responsible for delivery of mental health care within the catchment area.

The tasks will include:-

2.2.1 Education and guidance of the section committee on matters relating to mental health with emphasis on understanding the factors which can lead to mental ill health and early recognition of persons who have emotional or mental problems.

2.2.2 The assessment of all patients with psychiatric problems to decide whether treatment can be provided at the rural Health Centre or whether referral is needed. They should be able to deal with acute excitements, acute confusional states and epilepsy.

2.2.3 Maintenance of treatment and promotion of the rehabilitation of persons disabled by mental illness.

2.3 Urban Clinic

A team including a Medical Assistant Psychiatry and an Enrolled Psychiatric Nurse will be developed at this level. Their duties will be similar to those performed at the Zonal Health Centre.

2.4 Zonal Health Centre

It is proposed to introduce the Medical Assistant Psychiatry (MAP) and the Enrolled Psychiatric Nurse (ZPN) at this level as an integral part of the staff at the Zonal Health Centre. No specialised psychiatry beds are proposed. However, the same general beds may be imployed for short term care of the mentally ill as and when necessary.

This team will perform the following functions:-

2.4.1 Promotion, supervision and evluation of mental health care within the zone in liaison with the Rural Health Centres through regular visits. This will include assistance in continued education of community Health Workers and the provision of suitable material for dissemination to the community.

2.4.2 Advising on the care of patients at the Rural Health Centre and the provision of a referral service.

2.4.3 Promotion of intersectoral cooperation for mental health, e.g. police, social work and education.

2.4.4 Collection of mental health Statistics.

2.5 District Hospital

It is proposed to introduce provision for short stay in-patient care in the proportion of one bed for 15,000 population (4 to 6 beds). The district hospital will provide the following services in mental health care:

2.5.1 In-patient services

2.5.2 Out-patient services

2.5.3 Regular visits to Zonal Health Centres and Rural Health Centres for supervision, support and evaluation of services.

2.5.4 Provision of advice to the District Council for intersectoral cooperation through the Medical Officer-in-Charge of the hospital.

2.5.5 Collection of mental health statistics.

Staff will be as follows:-

Staff	Small DH	Large DH
S.M.A Psych.	1	1
M. A. Psych.	0-1	1
ZEP Nurse	1-2	2-3

The functions of the mental health team at the District Hospital will closely correspond to these at the Zonal Health Centre.

Chapter 2.12 COST

12 COST

1. INTRODUCTION TO COST ESTIMATES 1980-89

In preparing the estimates of cost for primary health care over the ten year period 1980-89 the aim has been to present ALL costs which will affect the development of the programme. Estimates include direct primary health care costs and costs of back-up services which are essential if primary health care is to function effectively. Thus costs of all services from the level of the District hospital to the community level have been included. In addition estimates for the following have been included.

1.1 Extra Mapower

The additional manpower recommended in Chapter 2.5 have been costed for training and salaries when they have been deployed. It is probable that not all of these extra workers will be deployed in the primary health care system. Thus to an extent this estimate is excessive.

1.2 Staff Housing

At first sight this may appear to be an inappropriate addition to primary health care costing. It is not. Unless the present exteme shortage of staff houses in rural areas is corrected it will not be possible to deploy staff at rural health centres and hospitals and the development of primary health care will be seriously impeded.

It should be noted that the estimated cost of K9000 per house is dependent on a considerable self help component by the local communities.

2. ADDITIONAL NOTES ON COST ESTIMATES

2.1 Transport

2.1.1 Bicycles

2.1.2

It is estimated that a motorcycle can last for 3 years before write off. This is based on estimated travel of 25,000 km each year in rural conditions.

2.1.3 Four wheel vehicles

Vehicles such as Land Rover and Toyota Land Cruiser can last for 5 years with good maintenance and travelling 60,000 km each year before write off.

2.2 Health Centres

The cost estimate for new rural health centres is based on community participation in provision of some materials e.g. bricks, and labour. Staff housing must also be included for a new health centre.

3. CONCLUSION

The estimates must be seen as covering a ten year period (1980-89) during which the foundations of the primary health care system must be laid. Inevitably this will require extra inputs to provide for new buildings and training of extra staff including the new cadre of Community Health Workers.

The total cost, both capital and recurrent, amounts to K101,283,700. This represents an annual cost of some K10 million. However, the annual cost of the University Teaching Hospital is now approximately K11 million. On this basis the provision of a national health system for ALL the people is surely worth it.

4. PRIMARY HEALTH CARE COSTS 1980-89 (at 1979 price levels)

		CAPITAL	RECURRENT (Totals)	TIMETABLE
1.	TRAINING			
1.1	Training of existing health staff and personnel from other sectors	-	425,000	1980 - 84
1.2	Public education	-	200,000	1980 - 89
1.3	Training and deployment of CHWs (based on an estimate of 1000 trained each year i.e. 20 per District approx.) Includes provision of basic drugs	-	3,000,000	1980 - 89
1.4	Training of increased manpower	-	11,484,500	1982 - 89
	TOTAL		K15,109,500	
2.	ADDITIONAL MANPOWER			
	Salaries of increased health staff i.e. the extra recommended in Chapter 2.5	-	K6,624,200	1984 - 89
3.	TRANSPORT			
3.1	Health centre level (1500 bicycles)	450,000	-	purchase 1980 - 89
3.2	Health Zone level (88 motorcycles, 88 four wheel vehicles)	2,100,000	9,400,000	(purchase 1980 - 82
3.3	District level (43 ambulances based at District hospitals)	1,550,000	4,300,000	(recurrent 1980 - 89
	TOTAL	K4,100,000	K13,700,000	
4.	DRUGS AND SUPPLIES			
	Due to method of budet allocation details of expenditure for District hospitals and health centres are not readily available. This may be an underestimate	-	K20,000,000	1980 - 89

		CAPITAL	RECURRENT	TIMETABLE
5.	HEALTH CENTRES AND STAFF HOUSING			
5.1	Rural health centres			
5.1.1	200 new RHCs (stage I)	7,000,000	-	1980 - 89
5.1.2	250 RHCs upgrading (50 to Stage II, 200 general improvement)	5,500,000	-	1980 - 89
	Note: Urban clinics not included			
5.2	Zonal health centres			
	20 Stage II and 20 Stage I upgraded to ZHCs	3,000,000	-	1980 - 89
5.3	Staff housing			
	1600 new houses i.e. 1200 at RHCs and ZHCs, 400 at Zonal hospitals	15,000,000	-	1980 - 89
5.4	Maintenance	-	750,000	1980 - 89
	TOTAL	K30,500,000	K750,000	
6.	ZONAL AND DISTRICT HOSPITALS			
6.1	Zonal hospitals			
	10 ZHCs upgraded to Zonal hospitals	3,000,000	-	1980 - 89
6.2	District hospitals			
6.2.1	5 new 50 bed hospitals	7,500,000	-	1980 - 89
6.2.2	General improvements to existing units)	Costs cannot be estimated at present. Must await an inventory of existing facilities and production of a hospital development plan.		
6.2.3	Drug storage facilities at all hospitals)			
6.2.4	Maintenance at 5%)			
	TOTAL	K10,500,000		
	PRIMARY HEALTH CARE TOTAL COST	K45,100,000	K56,183,700	1980 - 89

Note: K1 = U.S.$1.3

Chapter 2.13 FINANCING

13. FINANCING

1. INTRODUCTION

Inadequacy of basic health services is not only a reflection of inadequacies in funds but also in financing policy and organisation. It is therefore necessary to analyse deficiencies in the existing financing system as a prelude to reorganisation. There are at least four factors which have contributed to the present inadequacy in resource allocation and utilisation for Primary Health Care-inadequate budgetary allocation, inefficient utilisation of funds, maldistribution and underutilisation of community participation.

1.1 Budgetary Allocation

The total budgetary allocation for health has risen from K11 million in 1966 to K64.5 million in 1980. During the same period the purchasing power of the Kwacha has declined considerably due to inflation and devaluation. In the meantime, health facilities have expanded as shown by the increase of health centres from 343 in 1966 to 716 in 1980, and the hospitals from 51 in 1966 to 82 in 1980. Moreover, the demand for services has increased as shown by a population increase of 3 per cent per year and the increase in hospital attendances.

1.2 Inefficient use of funds

There is evidence of inefficient utilisation of the funds allocated. The loss of drugs through theft as shown by the Bowa Report is one example of wastage, but there are many others.

1.3 Maldistribution of resources

The three Central Hospitals at Lusaka, Kitwe and Ndola account for 35 per cent of public expenditure on Health services. Although these institutions serve as referral centres it is known that they cater for the population in their immediate vicinity. Other examples of maldistribution of facilities have been give in Chapter 1.1

1.4 Underutilisation of community participation

Public expenditure on health is only a fraction of total national health expenditure. Nearly all families spend in cash or in kind large amounts in support of the health.

The funds may go to private practitioners, traditional practitioners and other health related activities. Thus, in those rural areas which are not reached by public health services it must be assumed that all expenditure on health is met by private resources.

There is a wealth of good will in favour of health services. Many people and organisations are ready to finance in cash or in kind the care of individuals or communities. This immense good will has not been utilised fully because there are administrative factors which are not condusive to community support. For example delay in responding to an offer may result in loss of the offer. This unreceptive atmosphere in the public services applies equally to support from the international community.

A few factors will have to be taken into account in reorganising the financing system in favour of basic health services. These are discussed below:

2. APPROACHES TO REORGANISATION OF FINANCING

Five approaches are discussed: Central Government, Local Government, insurance, private and community support.

2.1 Central Government

Central government should continue to be the major source of funds. Although in 1980 the budgetary allocation for health stood at 10 per cent of total national expenditure this will be insufficient for the effective implementation of the plans put forward in this document. More funds will be required.

At the very least there should be an annual increase in the allocation to cater for inflation and all recurrent expenditure resulting from national and international capital inputs.

When allocating funds the Ministry of Health must clearly separate capital and recurrent expenditure for PHC from the allocation for secondary health facilities. Clearly a similar separation in accounting must follow in order to facilitate a proper monitoring system.

2.2 Local Government

In the cities local authorities already spend considerable amounts on health services and it is possible that this source could expand. The Ministry of Health will encourage local authorities to discuss this possibility.

Although it should be examined more closely, it is unlikely that similar inputs could be raised by local authorities in rural areas.

2.3 Insurance systems

In many countries the entire support for medical care is based on medical insurance contributions. However, in Zambia the proportion of the population in paid employment is small and an insurance system would be unlikely to be applicable in rural areas.

Nevertheless as a means of raising revenue for health care an insurance system is a possibility and the Ministry of Health intends to conduct a feasibility study.

2.4 Private financing

Private expenditure on health, whether personal or through industrial and other corporation, will continue to contribute to the health care of individuals. Private practices should continue but cannot be expected to make a significant impact on the national level of primary health care.

On the other hand contributions by private companies and corporations can be considerable and the Ministry of Health will encourage these enterprises to provide health facilities for employees and, where appropriate, for their families and the local population.

2.5 Community Participation

The favourable will of the community to participate in health services development will be mobilised through the organisational structure proposed in Chapter 2.1 and 2.2. This harnessing of resources should include the following activities:-

- Production Units
- Contributions in kind
- Contributions in cash
- Self-help projects
- Family Health Insurance Schemes
- Organised Distribution of Private Practices
- Encouragement and serving of Company medical facilties.

3. MECHANISMS FOR FUNDING

3.1 Decentralisation of Financial administration

Decentralisation of financial administration is essential for the effective development of primary health care. At present only capital expenditure on primary health facilities is provincially controlled.

During 1981 it is intention of the Ministry of Health to work out mechanisms for capital and recurrent expenditure to be decentralised with some facility for recurrent expenditure at District level.

3.2 Primary Health Services Development Fund

A fund for the development of PHC should be set up. The fund would be administered by Government and contributions would be encouraged from any source from community to industry. It would be separate from increased government allocation to the Ministry of Health.

It is the intention of the Ministry of Health to pursue the ways and means of establishing such a fund.

3.3 Health Services Revenue Unit

A revenue unit should be established within the Ministry of Health. The Unit would be responsible for the generation of funds and reduction of wasteful expenditure by monitoring the performance of medical institutions.

Funds could be raised from the following:-

i. Routine medical examinations e.g. for applicants for employment.

ii. Certain appliances e.g. spectacles

iii. Certain services to Foreign Missions

iv. Drugs in stores run or designated by Government.

The Party will be requested to consider the possibility of generating revenue in this way within the framework of the accepted policy of free medical services.

3.4 External Support

The whole plan for Primary Health Care is based on funds generated nationally. However, the international community will continue to be encouraged to give support to specific programmes, as outlined in this document.

Chapter 2.14 EVALUATION AND INFORMATION SYSTEMS

14. EVALUATION AND INFORMATION SYSTEM

Evaluation refers to the process of measuring the extent to which a health programme achieves its objectives, It is an essential part of any health system since it provides those responsible for planning and management at all levels with information to make rational decisions. It is particularly important for primary health care in Zambia at a time when resources are strictly limited but the health needs of the people are very great. Evaluation enables decision makers to indentify areas of greater need, establish rational priorities and allocate resources to meet the needs effectively.

Evaluation of the PHC programme will proceed in two overlapping phases:-

i. evaluation of implementation of the programme throughout the nation

ii. development of a simple evaluation system as an integral part of PHC activities within each PHCU. As the basis for a reorganised and simplified national health information system.

1. ACTIVITIES TO BE EVALUATED

During the implementation phase particular attention will be paid to community participation and intersectoral cooperation. Evaluation will seek to identify the nature and extent of community participation as well as the extent of coordination with the development programme of other secfors. Means of improving participation and cooperation will be identified.

In addition each of the component programmes of PHC will be evaluated according to established objectives and priorities. These programmes are:-

- health education
- promotion of adequate nutrition and food supply
- promotion and maintenance of a safe water supply and basic sanitation
- maternal and child health services, including child spacing
- immunisation
- prevention and control of locally endemic diseases
- promotion of mental health

For all of these evaluation will aim to establish the needs for each community and assess the extent to which available resources (mainly manpower, equipment and budget allocations) are utilized to meet the needs effectively. This will entail measurement of the overall impact of PHC on the health of each community and this will be expressed, as far as possible, in terms of change in the health status of the people e.g. reduction in deaths and episodes of illness due to particular diseases.

NOTE: The information required to carry out an evaluation is rather detailed and is not included in this chapter.

2. PROCEDURES

2.1 Within the District

Since primary health care includes all health related activities from the community level up to and including the District Hospital then evaluation within the District is of fundamental importance

Within the District Management Team the PHC co-ordinator will be mainly responsible for carrying out evaluation.

Information will be obtained from two main sources, as follows:-

2.1.1 District Survey

An annual survey will be conducted in each District. The aims will be :-

- to identify the main health problems of the people and thus to workout their health needs in order of priority

- to identify and quantify the resources available to meet the needs and to identify any serious resource gaps e.g. drug supply and transport.

Information will be obtained from RHC and hospital records, records maintained by other sectors e.g. Department of Water Affairs, community leaders and small samples of individual households.

Base line District surveys will be initiated in early 1981. These will commence with the preparation of maps of the areas of responsibility of each RHC and hospital. Team work will be essential and the PHC Co-ordinator will enlist the support of the Health Assistant at each RHC in producing the map. Subsequently copies will be retained at each RHC for the use of the staff in planning activities such as immunisation field days and supervision of CHWs.

2.1.2 Health Information System

The national health information system is currently being reorganised in order to make it more appropriate for planning and management needs at the District and RHC levels. Reorganisation will involve a reduction in the amount of information recorded and despatched to the Ministry of Health Headquarters. New simplified clinic and hospital recording sheets have been designed and will be tested during 1981.

Under the new system essential information from the community, RHCs and hospitals will be processed at District level, the information being used by the District Management Team in the development of the PHC programme. Copies of the data will be forwarded to the PMO and Ministry of Health Headquarters.

The information will be supplemented, where necessary, by District or sub District surveys (see above)

2.2 At Provincial level

Regular reports from the District will be forwarded to the PMO for evaluation on a Provincial basis. In addition progress of projects for which the PMO is responsible will be evaluated e.g capital projects.

A feedback mechanism will be established between Provincial and District Management Teams whereby information on development of PHC in all the Districts will be distributed. This will enable each District Management Team to compare its performance with each of its fellow Districts.

During the years when evaluation and health information systems are being developed the Provincial Management Teams will conduct training seminars for health personnel to assist them in establishing their own evaluation systems at District and RHC levels.

2.3 At Central level

Evaluation at central level will rely on three main sources of information. These are:-

2.3.1 Annual District surveys

2.3.2 Health Information System e.g. RHC monthly returns

2.3.3 Resource allocation date i.e funds, personnel etc.

The Health Information System is being re-organised so that only essential information is routinely recorded. It is intended that the major reduction in routine data recording will speed up the communication and processing of data between District, Provincial and Central levels.

Information on resource allocation will be a most important evaluation measurement in the PHC programme. Trends from year to year to year will clearly show whether the present maldistribution between urban and rural areas is being corrected. It is intended to examine allocation of funds, personnel, new health centres, upgraded health centres, staff accommodation and transport.

STRATEGIES AND TIMETABLE FOR PRIMARY HEALT CARE

1. NATIONAL COMMITMENT TO DEVELOPMENT OF PHC
2. ORIENTATION OF STAFF
3. PUBLIC EDUCATION
4. STENGTHENING OF PHC MANPOWER
5. IDENTIFICATION OF COMMUNITIES
6. TRAINING OF NEW STAFF
7. TRANSPORT
8. DRUGS AND SUPPLIES
9. BUILDING PROGRAMME
10. EVALUATION

STRATEGIES AND TIMETABLE FOR PRIMARY HEALTH CARE

The overall objective for which the strategies are intended is to provide essential health care for the entire population.

	STRATEGIES	TIMETABLE
1	**NATIONAL COMMITMENT TO DEVELOPMENT OF PRIMARY HEALTH CARE**	
	During 1980 the proposals for the PHC programme have been discussed at District and Provincial seminars and at a National Primary Health Care conference. Suggestions and recommendations arising from these discussions have been incorporated in this document.	
	Subsequent strategies are as follows:-	
1.1	Submission of planning document to Central Committee/Cabinet as necessary	JAN 1981
1.2	Discussion of PHC proposals at community level	1981-82
1.3	Strengthening of mechanisms for intersectoral co-operation at District Provincial and Central levels	1981-82
2.	**ORIENTATION OF STAFF**	
2.1	Health staff Training of existing staff, especially health centre workers, for their new role in PHC	1981-84 with main trust 1981-82
2.2	Other sectors	
	Education of staff from relevant sectors, including Party workers,-and village Headmen to prepare them for participation in PHC	1981-84 with main trust 1981-82
3.	**PUBLIC EDUCATION**	
	Education of the people and their representatives about PHC and their participation in their own communities.	1981 onwards but special thrust 1981-84

4.	STRENGTHENING OF PHC MANPOWER	
	Strengthening of staff responsible for organisation and evaluation of the Primary Health Care Programme at District, Provincial and Central levels. The Primary Health Care Co-ordinators are the most important cadre	1981-84
5.	IDENTIFICATION OF COMMUNITIES	
	Following community level seminars on PHC in each District communities will initiate the process of organisation and mobilisation through the PHC Co-ordinators. Ideally such communities should lie within the catchment areas of one or two adequately staffed RHCs for the purposes of training and providing support for CHWs.	JAN 1981 onwards
6.	TRAINING OF NEW STAFF	
6.1	CHWs	
	As indicated in 5. training will take place within Districts at well staffed RHCs. In the first year a total of 10 CHWs in each District should be regarded as a realistic target.	JAN 1981 onwards
6.2	Other health staff	
	As recommended in Chapter 2.5	1981-89
7..	TRANSPORT	
	Provision of transport as recommended in Chapter 2.7. Priority should be give to Primary Health Care Co-ordinators and staff of RHCs where PHC has been initiated.	1981-82
8.	DRUGS AND SUPPLIES	
	Improvement of drug requisition and deliver procedures as recommended in Chapter 2.8	1981-82
9.	BUILDING PROGRAMME	
	Priority must be given to health centre construction and upgrading and building of staff housing in the most needy rural areas.	1981-89

10. EVALUATION

There must be regular and frequent evaluation of the development of the Primary Health Care programme at all levels. In the light of evaluation reports strategies for future development can be reviewed and altered accordingly.

10.1 Tranining of Provincial and District personnel in planning, management and evaluation 1981-82

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